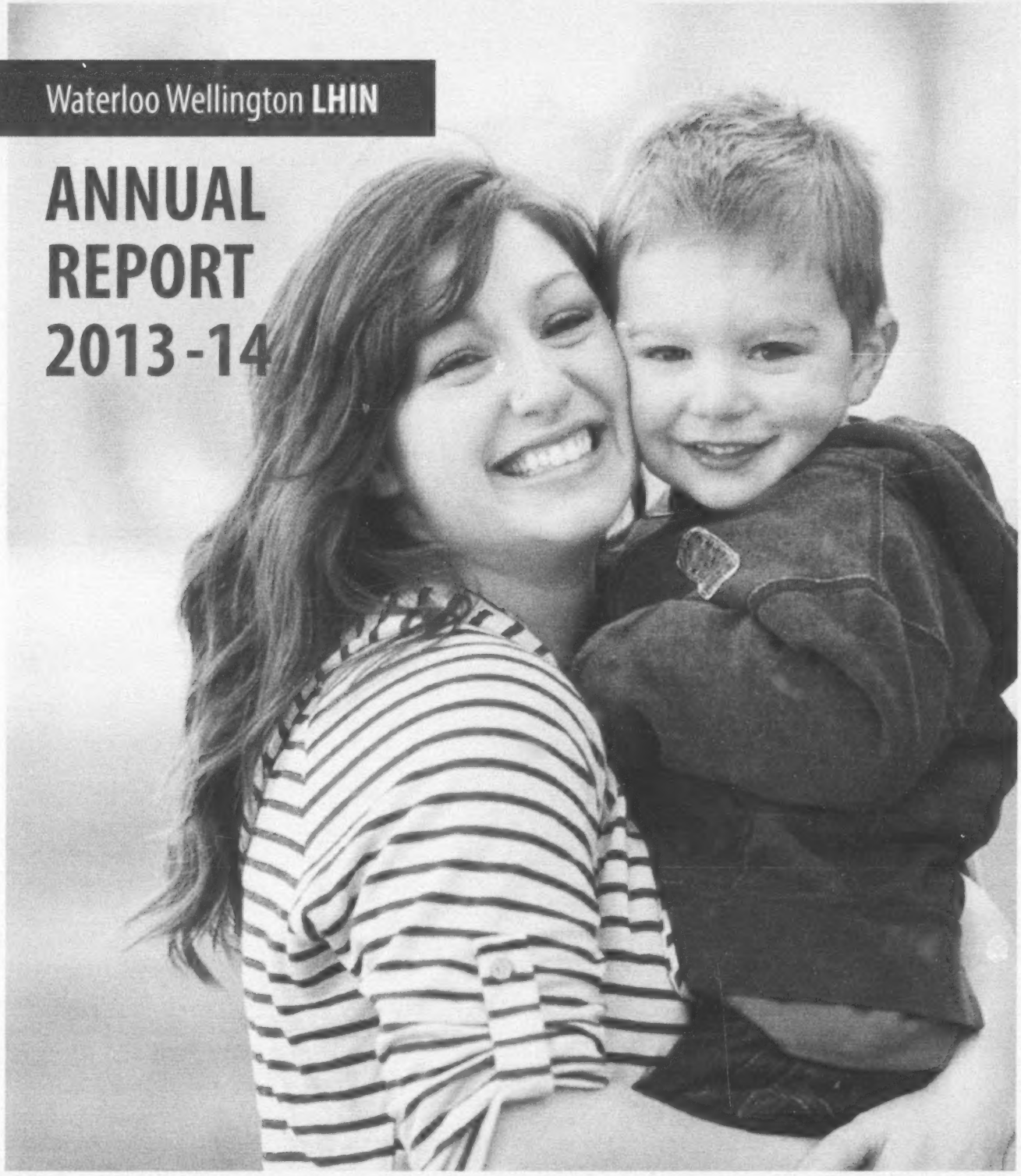
Waterloo Wellington **LHIN**

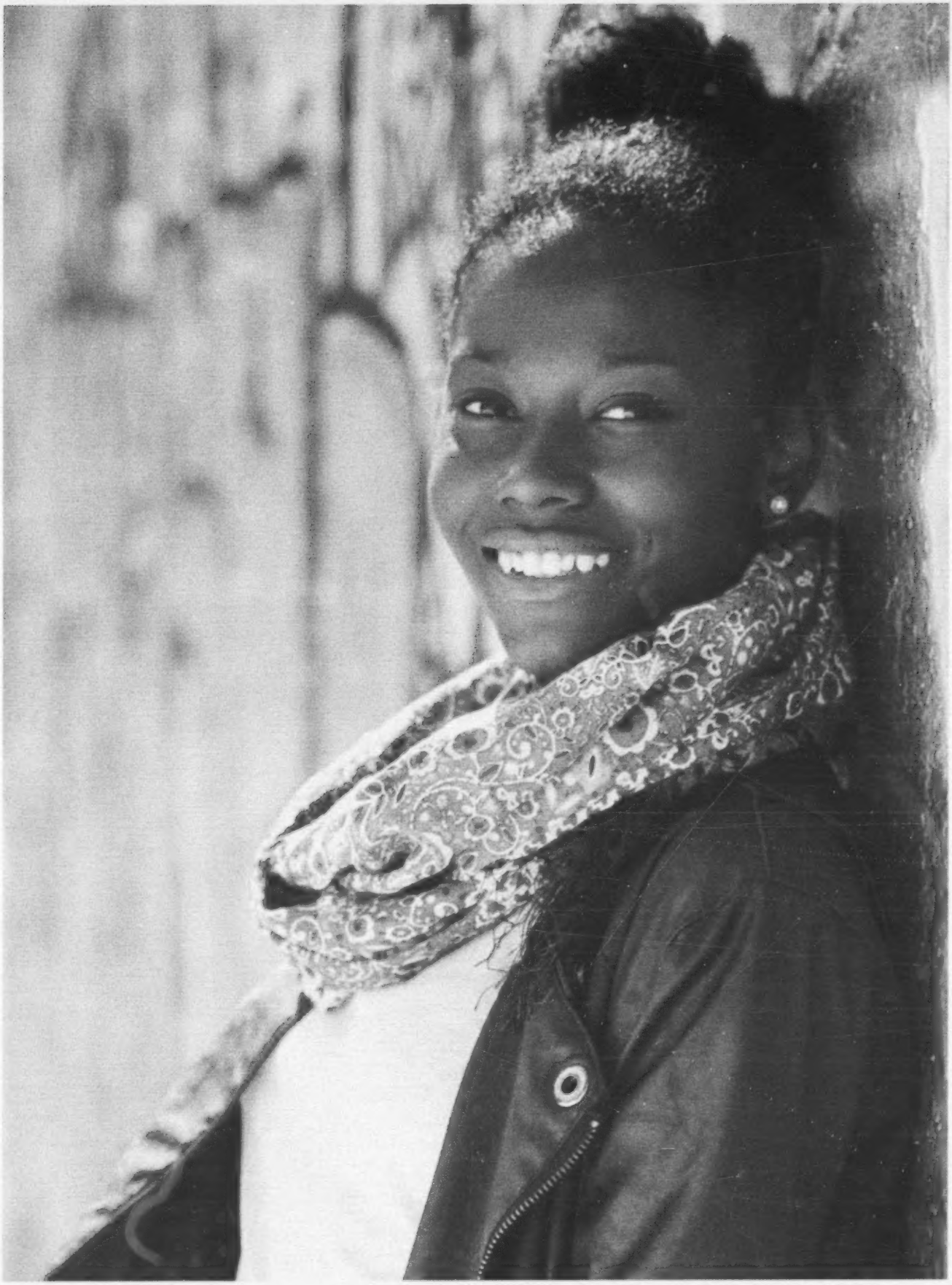
ANNUAL REPORT 2013-14



Ontario

Waterloo Wellington Local Health Integration Network

Réseau local d'intégration des services de santé de Waterloo Wellington



MESSAGE FROM OUR LEADERSHIP TEAM

On behalf of the Board of Directors, we are pleased to provide you with this 2013-14 Annual Report.

One of the true benefits of being a Local Health Integration Network is that we are local. Being local means we are deeply rooted in and have direct experience with the community we serve. Our children go to school together. We go to the same parks and libraries, and when we need medical care, we visit the same hospitals, doctors, and clinics.

We also regularly engage with local residents – whether that's with parents, caregivers, patients, clients, the homeless, and many others – to identify their health needs and what improvements can be made to better meet them. This feedback, along with input from health service providers, informs our collective plan to improve the health system – the Integrated Health Service Plan (IHSP).

We are here to support health providers as they work hard and collaborate to achieve the objectives set out in the plan. When necessary, we intervene to ensure the decisions that are made are in the best interest of our residents. We also lead the creation of programs that increase quality and ensure consistent levels of care across the entire health system.

Our system leadership and direction, combined with the dedication and hard work of our health service providers in their specific areas of expertise, has resulted in many improvements in our local health system. Residents are waiting months less for care. Thousands more residents have a family health care provider. Hundreds of residents are living longer after a serious health issue. And access to diabetes, addictions & mental health, and community care has been simplified to either one form or one phone number for referral.

We are proud of the progress made to improve our health system as demonstrated through the stories told and statistics shared in this Annual Report. These accomplishments wouldn't be possible without the commitment to improve and incredible efforts of our 77 health service providers and the more than 37,000 health care workers in our community. Thank you for everything you do each and every day for our residents.

Most importantly, thank you to our residents for helping us to understand the changes needed and for sharing stories of how our progress has improved your lives and the lives of your families, friends, and neighbours across Waterloo Wellington.

Sincerely,

Joan S. Fisk
Chair, Board of Directors

Dale Small
Vice Chair, Board of Directors

Bruce Lauckner
Chief Executive Officer

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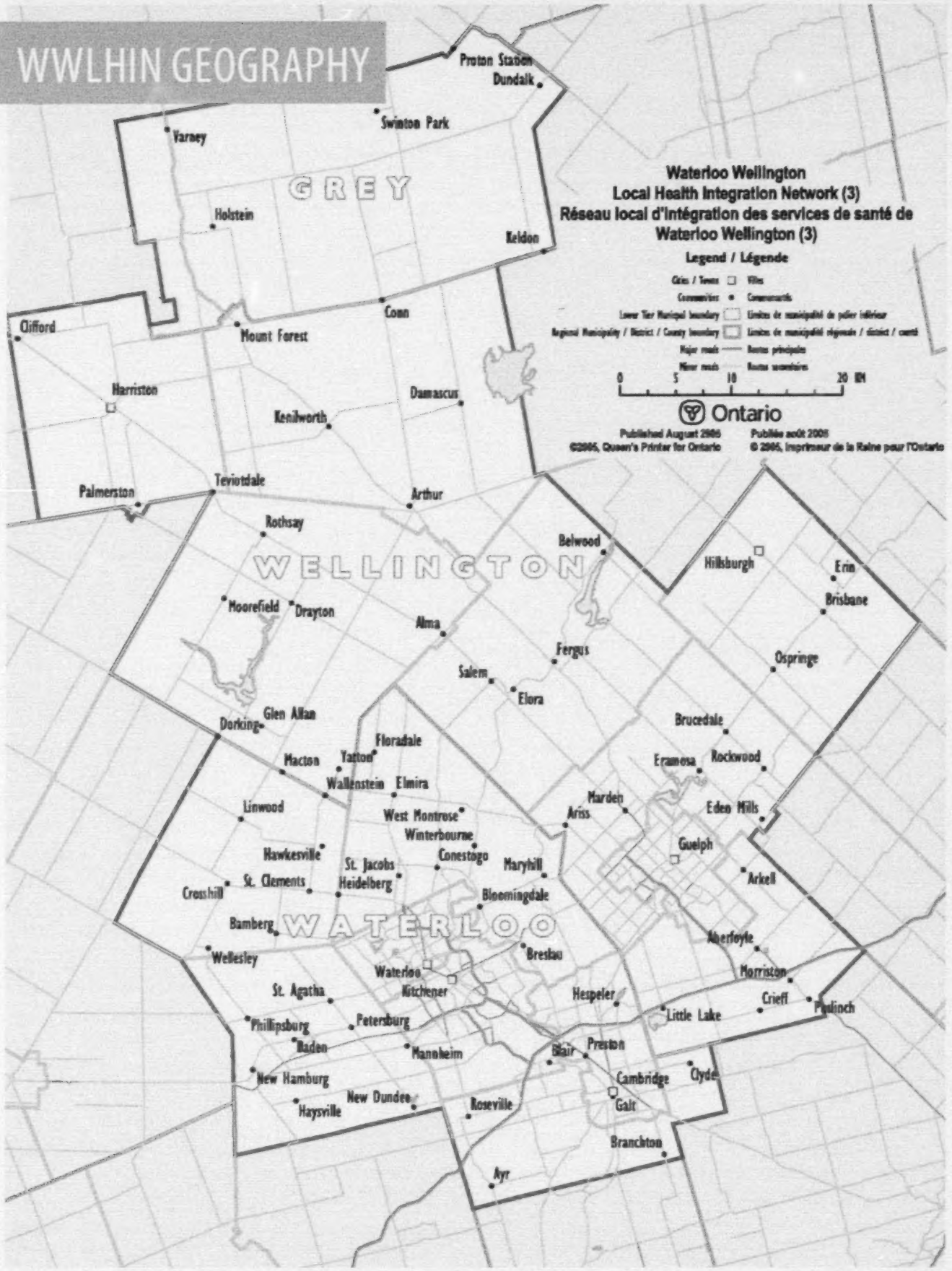
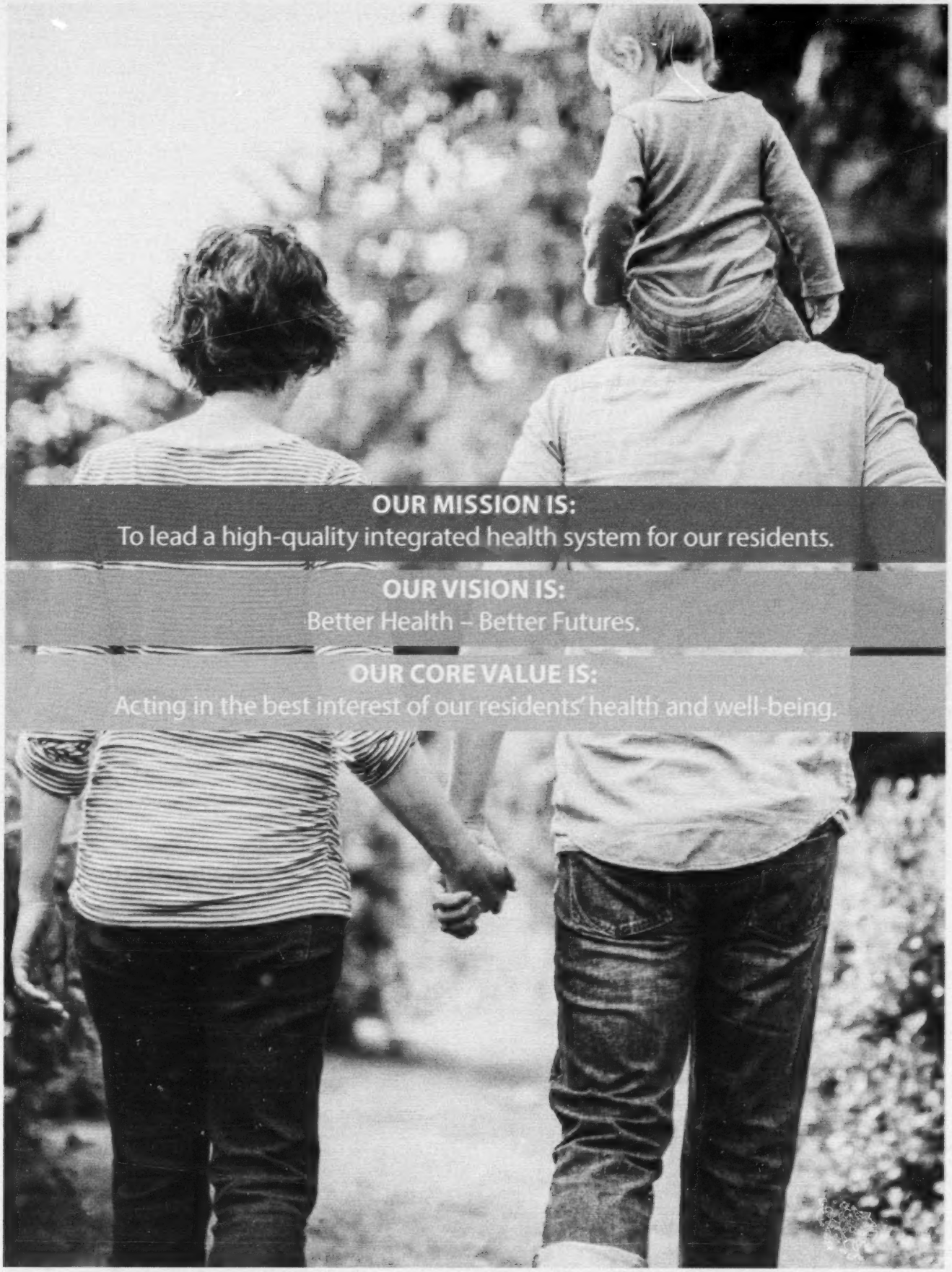




OUR MISSION IS:

To lead a high-quality integrated health system for our residents.

OUR VISION IS:

Better Health – Better Futures.

OUR CORE VALUE IS:

Acting in the best interest of our residents' health and well-being.

BOARD OF DIRECTORS 2013-14

Waterloo Wellington Local Health Integration Network Governance Structure

The Waterloo Wellington Local Health Integration Network is governed by a Board of Directors who are selected by the Lieutenant Governor in Council and appointed through Order in Council. Members hold office for a term of up to three years and may be re-appointed for one additional term. The Board is skills-based, drawing on local individuals with a variety of experiences and expertise. WWLHIN Board meetings are open to the public. There are three standing committees of the Board: Finance and Audit, Governance, and Nominations.

Transitions in Board Membership

After serving as a Board member since April 2011, the Board wishes to thank Bonnie Bremner for her contribution to the health and well-being of our residents as she moves on to exciting new opportunities. In November 2013, the WWLHIN Board welcomed Jeff Nesbitt, Vice President, Enterprise & Innovation at Communitech, to the Board.

Joan S. Fisk, Chair
Jun. 2, 2011 – Jun. 1, 2014
Reappointed: Jun. 2, 2014 – Jun. 1, 2017

Dale Small, Vice-Chair
Nov. 18, 2009 – Nov. 17, 2012
Reappointed: Nov. 18, 2012 – Nov. 17, 2015

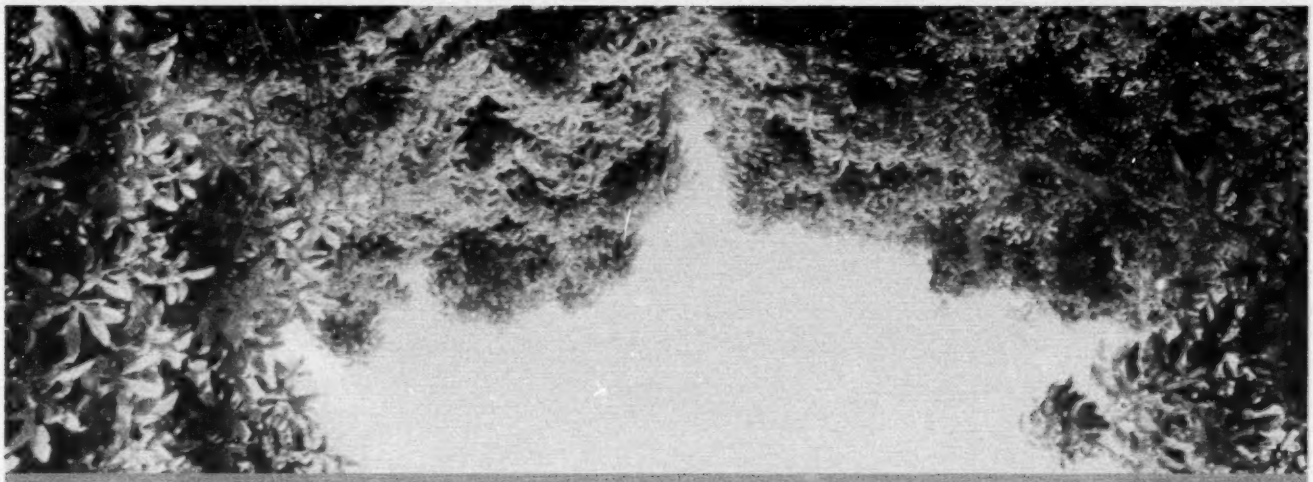
Manjit Basi
Oct. 6, 2010 – Oct. 5, 2013
Reappointed: Oct. 6, 2013 – Oct. 5, 2016

Murray O'Brien
Jun. 2, 2011 – Jun. 1, 2014
Reappointed: Jun. 2, 2014 – Jun. 1, 2017

William (Bill) Dinwoody
Dec. 2, 2009 – Dec. 1, 2012
Reappointed: Dec. 2, 2012 – Dec 1, 2015

Jeff Nesbitt
Nov. 19, 2013 – Nov. 18, 2016

Bonnie Bremner
Apr. 18, 2011 – Apr. 17, 2014
Retired from board: Mar. 2014

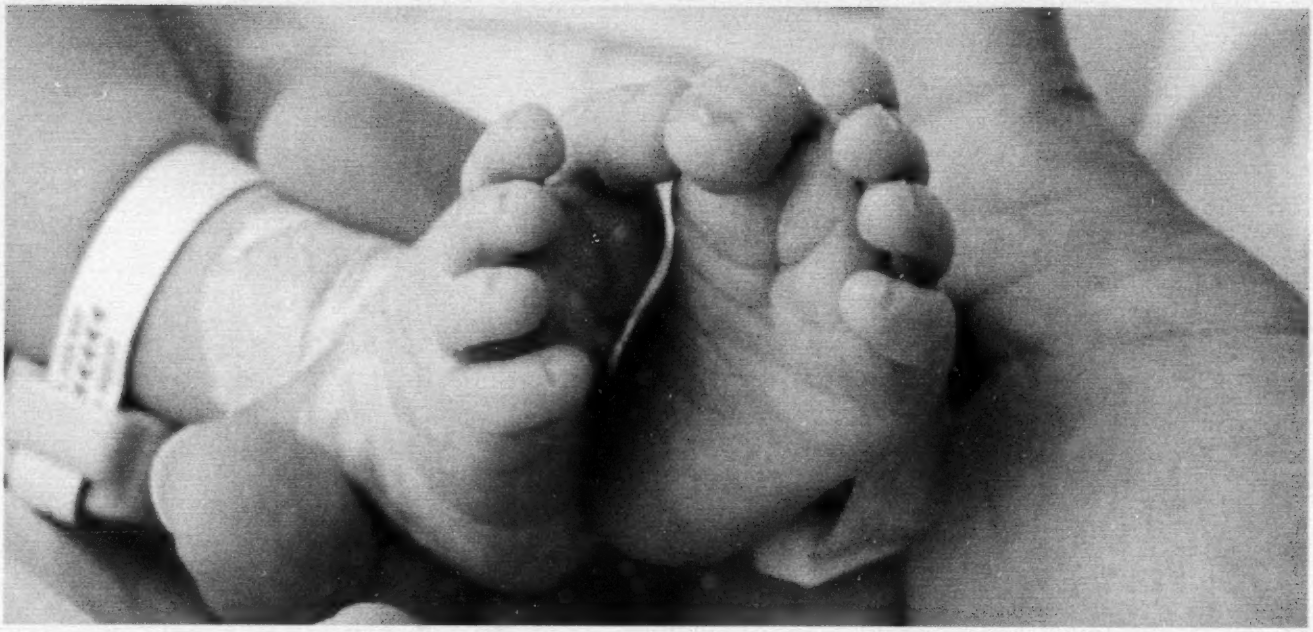


WHO WE SERVE

The Waterloo Wellington Local Health Integration Network serves approximately 775,000 residents in Waterloo Region, Wellington County, the City of Guelph, and the southern part of Grey County.

" LHINs have the ability to know what happens at the grassroots in communities and work with grassroots organizations to build a better system for people locally that responds to people locally."

– Ken Seiling, Chair, Region of Waterloo



OUR COMMUNITY PROFILE

The Waterloo Wellington LHIN is home to approximately 775,000 people, 5.7 per cent of the population of Ontario. Since 2007, the WWLHIN's population has increased, on average, by 1.2 per cent each year. The population of Ontario increased by 1.1 per cent annually during this same period of time. The WWLHIN has a relatively young population with 87 per cent of residents under the age of 65 years.

Although over 20 per cent of the population of Waterloo Wellington are immigrants and 11.7 per cent are visible minorities, these percentages are lower than the provincial average. Approximately 1.2 per cent of WWLHIN residents self-identify as Aboriginal. Two per cent of the population is French speaking.

Both the unemployment and low income rates in Waterloo Wellington are lower than provincial rates. Fifty-eight per cent of adults (age 25+) have attained post-secondary education credentials.

OUR HEALTH PROFILE

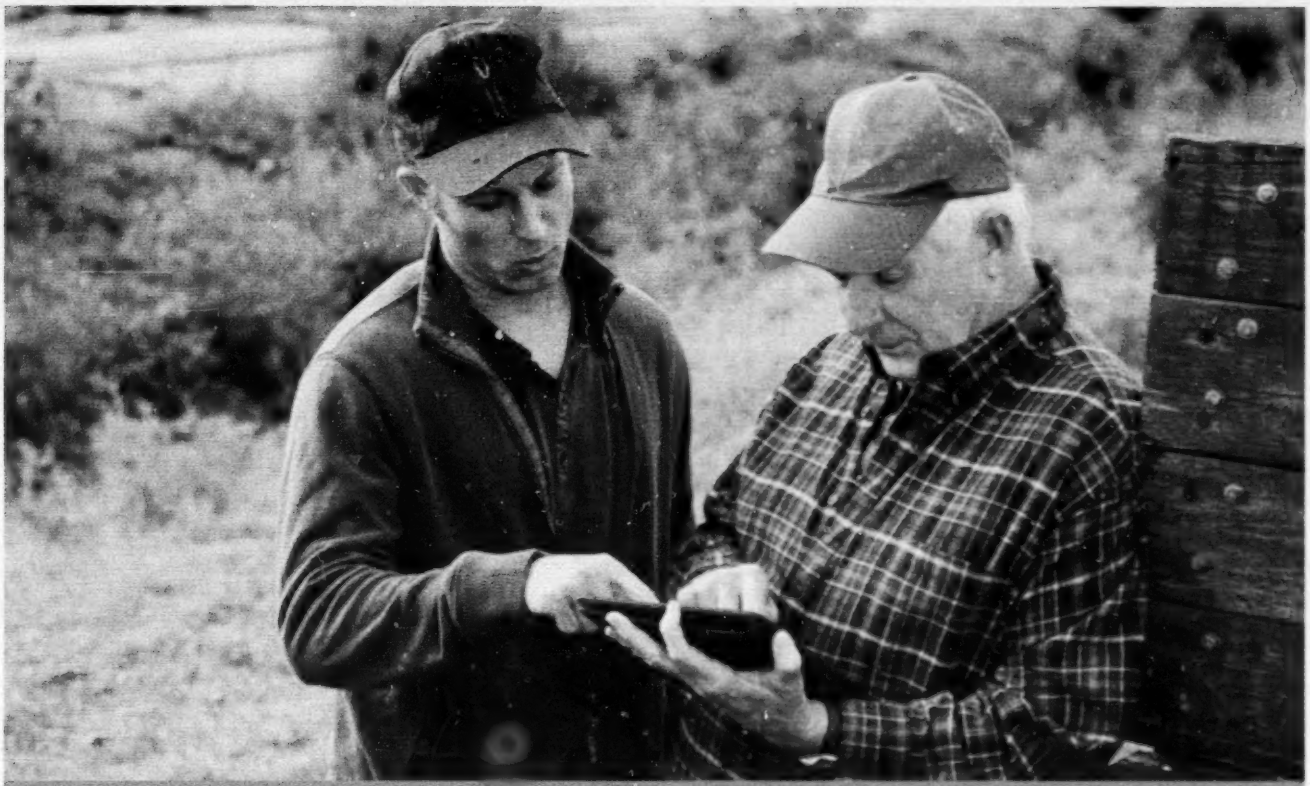
The health of residents in Waterloo Wellington is partly measured by a number of different health indicators. These indicators are compared to provincial averages to determine how healthy residents are compared to the rest of the province.

Life expectancy among males and females in Waterloo Wellington is similar to life expectancy for Ontario. The percentage of newborns classified as "small for gestational age" was less than the provincial average, while the percentage classified as "large for gestational age" was slightly higher. This is important because low birth weight is a determinant of infant health.

Self-reported health, an indicator of overall health status, can reflect aspects of health not captured in other measures. Waterloo Wellington residents are more likely than Ontarians to rate their overall health as "Excellent" or "Good".

Poor health practices are related to increased risk of chronic conditions, mortality and disability. Examples of poor health practices are smoking (20.3 per cent of residents smoke), not eating well (only 37.5 per cent report eating the recommended number of healthy foods), and not exercising (56.7 per cent report being physically active). More than 50 per cent of residents report that they are overweight or obese.

The chronic conditions with the highest mortality rates in Waterloo Wellington are cancer, ischemic heart disease and stroke.



WHY LOCAL IS SO IMPORTANT

Deeply Rooted in Our Community

No one knows better what is needed for our community than those of us who live here, work here, and receive health care here. That doesn't mean we can't learn from others. What it does mean is that solutions need to be tailored to fit our unique needs.

The Waterloo Wellington area is 90 per cent rural, yet 90 per cent of our residents live in urban areas. We have a growing high-tech hub, four internationally recognized post-secondary institutions, a nationally famous farmers' market and thriving agricultural industry, a vibrant arts and culture community from Drayton to Guelph and beyond, and much, much more. Our diverse population includes French-speaking, Aboriginal, Mennonite, and immigrant residents. While we have increasing education rates, we also have concentrated areas of poverty.

The medical and business professionals who work at the WWLHIN understand our community because they are local. Our children play sports and go to school together. We shop at the same grocery stores, we celebrate at the same festivals, and when we need medical care, we go to the same hospitals, doctors, and clinics. We meet at the same libraries and community centres, and we interact with many of the same service organizations as volunteers or clients. The doctors who work at the WWLHIN literally work with us and their patients in the same day.

As local residents, we are here to support providers as they collaborate to make improvements each and every day. When necessary, we intervene to ensure the decisions that are made are in the best interest of residents. We also lead the creation of programs that increase quality and ensure consistent levels of care across the entire health system. These are improvements that benefit us all.

Most importantly, we interact regularly with the residents who contact our office, and we formally engage our community to get their input and feedback. The changes made to improve local health are based on the input of local residents and local health care workers. They are also grounded in best practice and aligned with provincial strategy and vision.

This is the benefit of being local: Knowing the needs of our community, seeing the system view and where pieces need to be better connected, and leading local solutions that will improve the health of those around us.

WHY CHANGE IS NEEDED

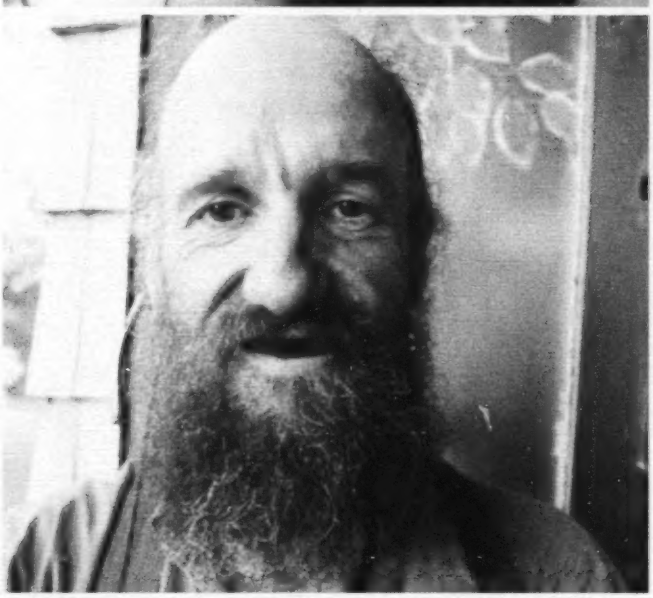
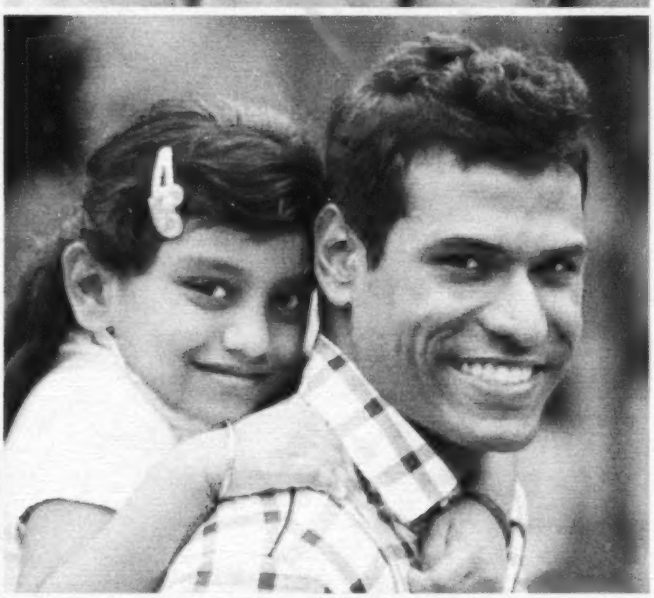
Less than a decade ago, despite the fact that there was a group of incredible, dedicated health professionals doing everything they could to improve care for their patients, there were many stories of where the health system was failing in Ontario – unacceptable wait times, a shortage of doctors, high readmissions to hospitals that could be prevented, higher mortality rates than expected, and ever-increasing costs.

Better coordination at the system level was needed to connect services, find efficiencies to free up resources for reinvestment, and improve access and quality of care. The LHINs were created to have a regional system-level view. Our mandate includes engaging with stakeholders to truly understand the needs of our population, and leading, funding and integrating the health system to make the changes and improvements needed.

While health service providers focus on meeting the needs of each patient and client who walks through their doors, the LHINs look at how patients move through and across the health system, and what they experience as their various health care needs are met. The roles are distinct in many ways, and collaboration is imperative, but both are vital.

Over the past eight years in Waterloo-Wellington, more doctors have been recruited which means more people have a primary care provider. Quality of care has been improved so fewer people are returning to hospital and more people are surviving health issues such as stroke. Wait times have been dramatically reduced so people are getting the care they need much faster. Community care has been simplified to either one-form or one-phone-number referral in many cases.

There is more work to be done – indeed, as needs continue to evolve and change, there always will be. But change for the better is happening – and that means better health and better futures for the residents of Waterloo Wellington.

Ontario's Action Plan for Health Care was launched in 2012 to build a quality health care system for Ontarians that is more responsive to patient needs and delivers better value for taxpayers. Its three priorities include: Keeping Ontario healthy, Faster access to stronger family health care, and Providing the right care, at the right time, in the right place.

In Waterloo Wellington, we have three priorities to improve the health of local residents:

- **Enhancing access to primary care;**
- **Creating a more seamless and coordinated health care experience;**
- **Leading a quality health care system using evidence-based practice.**

Throughout the rest of this report you will find information on what these priorities mean, why they are important, and what progress has been made over the past year. You will also read stories about how improvements are impacting the lives of local residents.

Local resident

Name changed to protect privacy

Representative of stories we have heard from local residents and caregivers.

PRIORITY: Enhancing Access to Primary Care

The goal: To ensure people have a primary care provider who is well connected with other health service providers.

What is primary care? Primary care is the first health care provider a person turns to with health concerns. It is often their family doctor or nurse practitioner but also includes chiropractors, naturopaths, or other health care professionals. A primary care provider is responsible for coordinating the specialized care required from other health professionals.

Why is this important? Take the case of a young man who had a strange rash on his legs. We'll call him Rahim. He didn't have a family doctor so he went to a walk-in clinic. The clinic was full so he went home and didn't receive care. Then there's the case of the young mother – we'll call her Neda – whose daughter had a fever for three days. She was worried and called her family doctor. The next available appointment was in two weeks' time so Neda took her daughter to the hospital. By enhancing access to primary care, both Rahim and Neda would have received quick care from a family doctor or nurse practitioner who knows them and their specific care needs.

Progress: Over the past year, with the LHIN's leadership, more residents have been matched with a primary care provider, providers are better connected together with other health and social services, and technology-use has been expanded to enhance quality of care.

MAINTAINING INDEPENDENCE

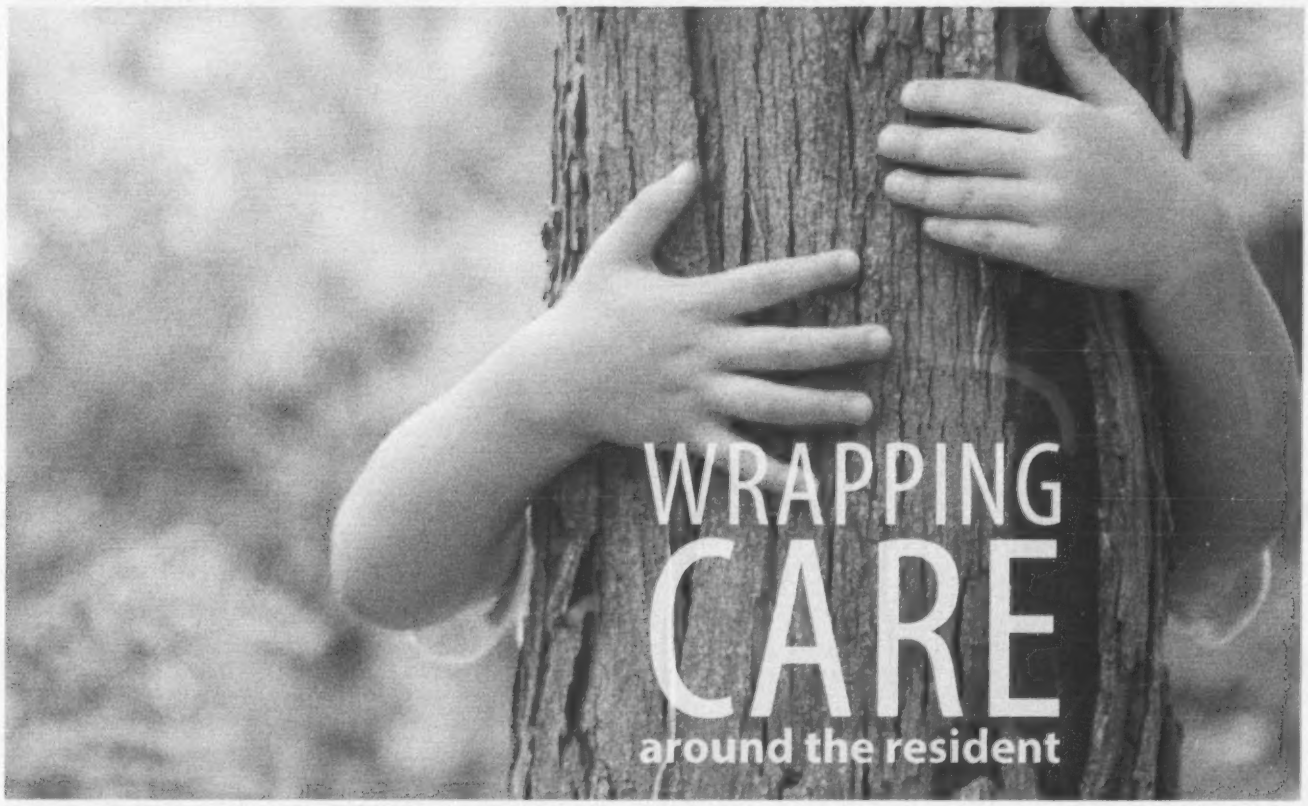
Independence has always been very important to Louis. Even though the 88-year-old resident of Guelph is widowed and lives alone, he takes great pride in being able to care for himself. His two sons help out as much as they can but live outside the area.

After having to stop driving because of memory concerns, Louis was referred to the Guelph Health Link for an assessment.

"During my initial assessment of Louis, I met a very pleasant man who was accustomed to caring for himself and proudly shared the fact that he walked to church every Sunday morning," said Heather, a Registered Nurse with the Guelph Family Health Team. "He was really happy living at home but I had a few concerns with his ability to safely care for himself. His legs were swollen, his blood pressure was high, and his memory impairment meant that he wasn't always the most careful when cooking, bathing, etc."

Health Links were launched this past year to wrap care and services around residents like Louis who have multiple-care needs. These residents benefit from a comprehensive care plan that is unique to their particular situation. They also don't need to worry about navigating the many services they might need – all of the right providers are brought to them.

Louis began receiving a number of community supports but it wasn't quite enough to meet his needs. "Louis's sons were increasingly worried about him. He was refusing to go to a day program, he had begun wandering in the neighbourhood, and one day when he set off the fire alarm, he was unable to communicate what he should do if there were a fire," said Heather. "Knowing how important staying at home was for Louis, I suggested to him and his family that a Health Link round table discussion occur to ensure he was



WRAPPING CARE around the resident

receiving the best support possible to enable his continued independence."

Key community partners including Louis, his family, a neighbour, his family doctor, the Primary Care at Home nurse, his Waterloo Wellington Community Care Access Centre care coordinator, the occupational therapist, Meals on Wheels, a St Joseph's outreach worker, a Community Responses Behaviour Team member, a Primary Care at Home social worker and a facilitator met to discuss how to better support Louis.

"Louis is now receiving care from personal support workers five days per week. He has supervision while cooking breakfast and is receiving proper personal care. Throughout the week his neighbours help him with orientation and safety. He also continues to see the foot care nurse through the Family Health Team and is receiving regular checkups by the Primary Care at Home Nurse and his family physician," said Heather. "The Health Link process to date has allowed a man, living alone at high risk, to stay in the comfort of his own home where he can be happy, healthy, and safe."

Louis

THEN

Residents with multiple or complicated care needs struggled to find the care they needed.

NOW

828 residents and counting, have integrated care plans connecting them with all of the services they need.

CONNECTING RESIDENTS WITH PRIMARY CARE

As a single mother with Multiple Sclerosis, Judy has significant challenges. Her health has declined rapidly over the past 10 years but that hasn't stopped her from being actively engaged with her two teenage daughters.

Her greatest concern comes from needing regular medical care to manage her symptoms. Her vision is poor, and sometimes she is overwhelmed by the numbness in her limbs.

"What is most important to me is staying positive for my family," said Judy. "Depression is a common side effect of my MS and something I've struggled with since my diagnosis. Thankfully with the help of my health team, I have received regular care that allows me to better care for myself and my family."

In 2011, Judy moved from Calgary to Stratford, leaving behind a doctor who had looked after her family for more than a decade. She spent months searching the internet, phoning doctors' offices and imposing on friends to ask their doctors if they would take on a new patient.

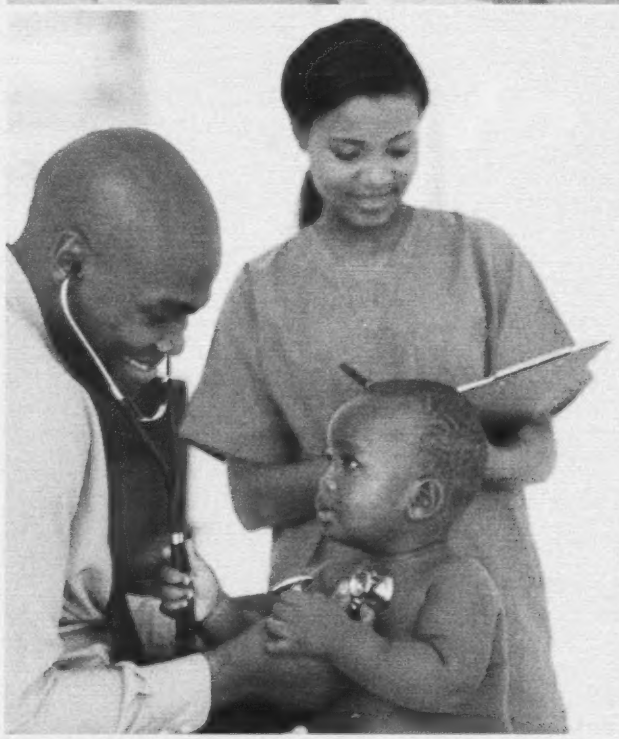
Judy had registered with the Health Care Connect program, but the program did not have any local providers in her area looking to take on new patients. Finally, two years after moving to the Stratford area, she saw a local newspaper advertisement stating that a new clinic was opening in her region and was able to register as a patient.

"I really wanted to move to the Waterloo area to be closer to my sister so she could help me and the girls," said Judy. "But I was terrified that we would be without medical care and I just couldn't take that risk."

Her sister, who had moved to the Waterloo Wellington area just a few months earlier, told her to try the Health Care Connect program again, because more doctors and nurse practitioners had signed up and the program's care connectors had been able to find her family a doctor right away.

Judy decided to give the program another try. They informed her that she would have to deregister with her current provider in Stratford and gave her information on how to approach her doctor and ask that they agree to continue to see her and her family until she was connected with a new provider locally. As Judy has complicated and multiple care needs, she and her family were put on a high priority list with the Health Care Connect program.

Within a week, Judy's care connector contacted her with the name and contact information of a local family health care provider who was able to take on Judy and her daughters as patients. "What was most amazing to me was how quickly they found us a new doctor, and that my current doctor was so supportive of us throughout the transition. As soon as we were settled, I saw my new doctor and we've been receiving wonderful care ever since."



THEN

Many residents had trouble finding a primary care provider.

NOW

92% of residents who have registered to find a primary care provider have been matched with one, as compared with 64% in 2012.

KEY STATISTICS AND ADDITIONAL HIGHLIGHTS

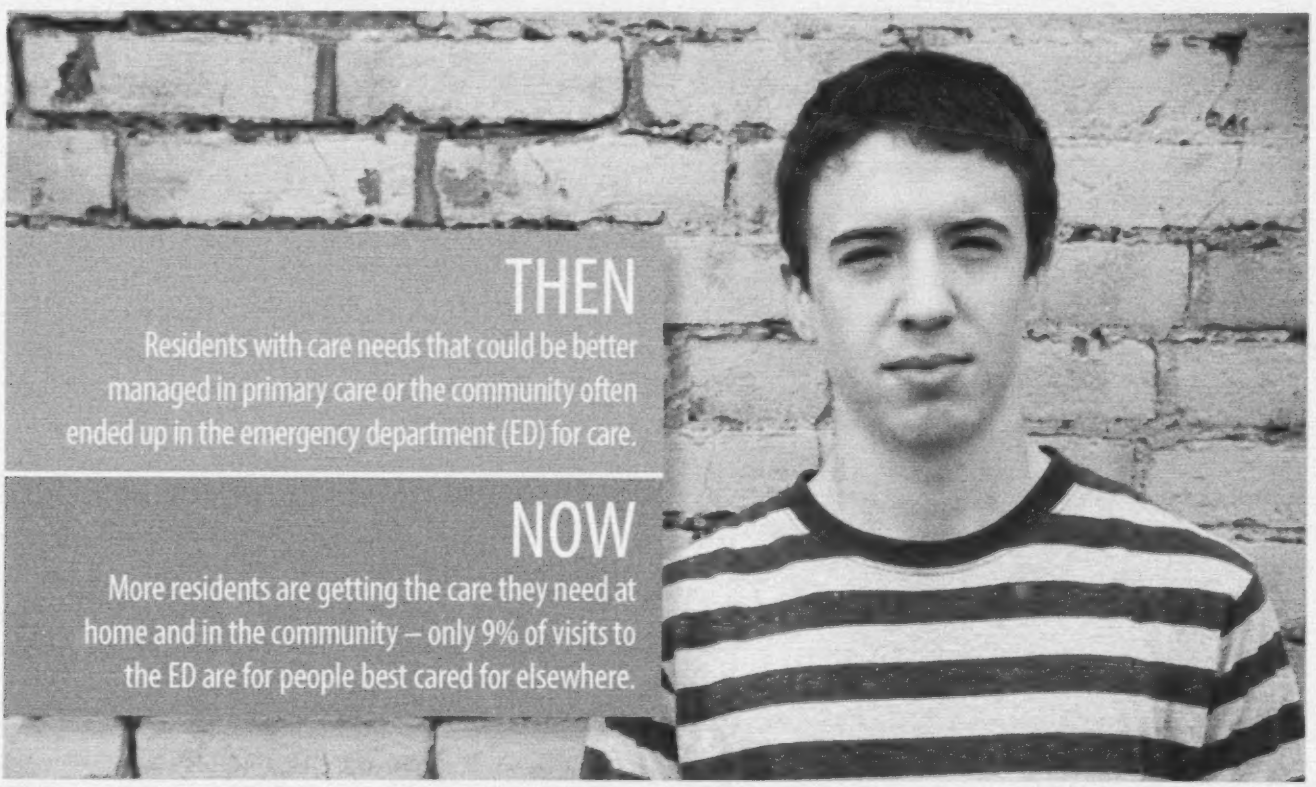
INTRODUCING HEALTH LINKS

One of the greatest accomplishments this year has been the launch of Health Links. Currently, 5 per cent of the users of Ontario's health system use approximately two thirds of the health care budget. This is because they have multiple care needs and often require care from different providers, as well as social, and other services. This care has typically been given in silos, creating duplication of effort and often with less than optimal outcomes.

The Health Links in Waterloo Wellington are providing leadership and energy in the health system by wrapping supports around individuals with complex care needs. Doing so will reduce duplication, improve efficiencies, prevent other health and social issues, and most importantly, provide better care for these residents.

Health Links tables include leaders from a variety of sectors including primary care, community support services, hospitals, addictions and mental health, Community Care Access Centre, emergency services, social services, and policing.

Four local Health Links are now established: Guelph; Rural Wellington; Kitchener,Waterloo Wellesley, Wilmot & Woolwich (KW[4]); and Cambridge and North Dumfries. The Guelph Health Link (the first to be announced in our LHIN) surpassed their goal of 500 care plans this year, resulting in 655 individuals in Guelph getting better care. In the first months of start-up, the other Health Links have created many coordinated care plans as well.


THEN
Residents with care needs that could be better managed in primary care or the community often ended up in the emergency department (ED) for care.
NOW
More residents are getting the care they need at home and in the community – only 9% of visits to the ED are for people best cared for elsewhere.

MORE RESIDENTS

are able to see their primary care provider the same or next day.

10,000 more

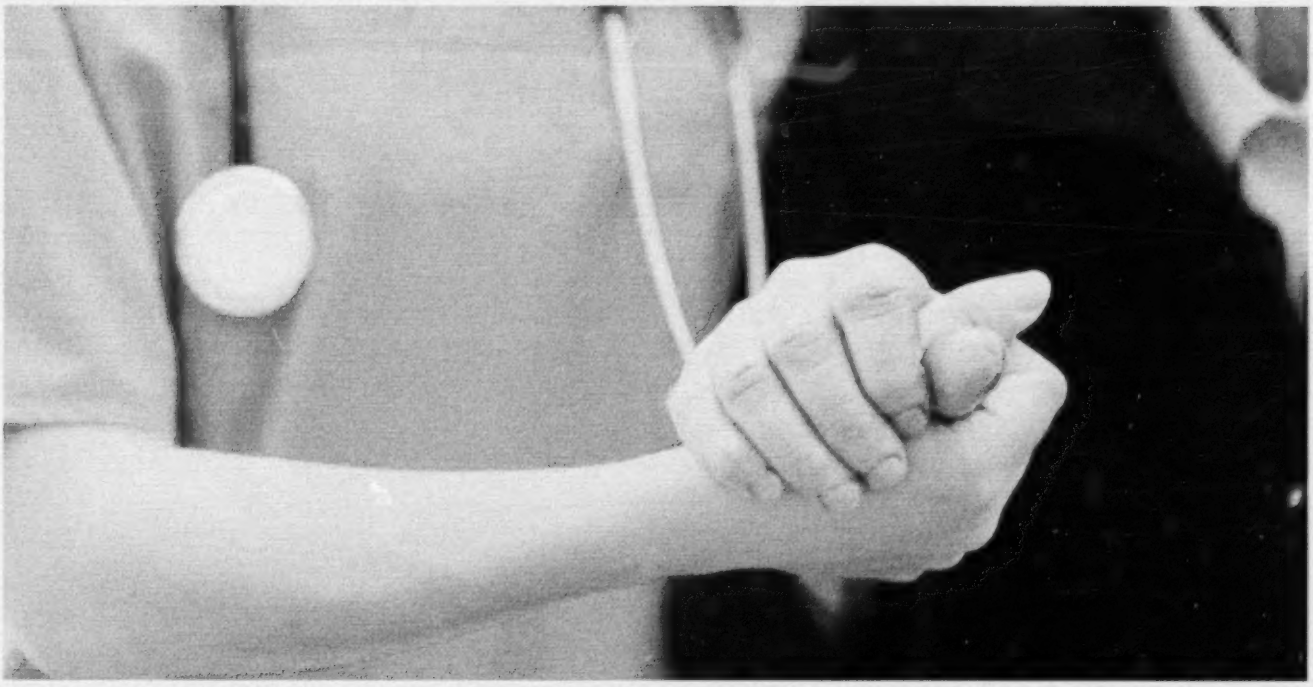
people with diabetes are accessing education and support services.

ALMOST 80%

of all family doctors, representing 550,000 residents, have the ability to use electronic medical records.

5,000 MORE

care appointments through telemedicine (seeing a specialist through video-conference to reduce the need for travel).



ENHANCING ACCESS TO PRIMARY CARE - PERFORMANCE REPORT

The past year marked significant progress in enhancing access to primary care for local residents. The Waterloo Wellington LHIN has not only met, but exceeded all of its local targets for Primary Care.

More than 800 integrated care plans have been developed for residents with complex care needs through Health Links. More than 90 per cent of those who have registered to find a primary care provider through Health Care Connect have been matched with one.

Fewer residents are being treated in the emergency department for health issues best treated elsewhere, helping to reduce emergency department wait times and providing better and more appropriate care for those in need.

Additionally, more providers (52 per cent more last year alone) are using Clinical Connect, a secure web-based portal to view their patient's health information from other providers online. This allows more timely sharing of clinical information between providers, improving the care experience for residents and improving health outcomes.

Next year, work will continue in these areas to connect even more residents with timely access to high quality primary care.

PERFORMANCE INDICATOR	System Starting Point*	Local System Target	Most Recent Local System Performance	LHIN Rank
Care Plans for High Need Residents[1]	-	504	655	N/A
Percentage Individuals Referred to a Health Care Provider[2]	13.0%	75.0%	92.0%	3
Emergency Visits Best Seen Elsewhere[1]	11.3%	10.3%	9.0%	5
New Users of Clinical Connect[1]	-	1,200	1,317	N/A

Legend

Note 1: These values are year-to-date starting April of a fiscal year

Note 2: These values are cumulative since beginning of program

* Starting Point: Performance prior to LHIN or first available data point after creation of LHIN

SPECIFIC 2013-2014 INITIATIVES AND RESULTS

GOAL	ACHIEVEMENT
Through Health Links across Waterloo Wellington: • Identify and ensure individualized care plans for high system users (top 5 per cent). • Build linkages between health, social services, justice, and other community partners.	Four Health Links were established across the LHIN and more individualized care plans were developed than the target for high system users. New partnerships were developed through Health Links and Connectivity Tables (Hubs). This model involves partners from a variety of sectors, including education, policing, and social services, which come together weekly to identify people who are at risk and develop immediate strategies to address their needs. Waterloo Wellington has been a leader in growing and developing this model. Community hubs in Cambridge and North Dumfries and in Guelph are starting to address the needs of individuals at risk, and a new hub – Connectivity Kitchener – was launched in May 2014.
Connect more people with a primary care provider, particularly seniors and individuals with complex needs by: • Assessing current primary care capacity throughout Waterloo Wellington and addressing service gaps. • Improving programs such as Health Care Connect to ensure residents who want a primary care provider can get one.	14,000 more residents now have a primary care provider – 7,000 of which were in the last year alone. Through care coordinator outreach with providers, doctor and nurse practitioner uptake in the program has increased. As a result of engagement with community partners and investment in primary care expansion from the WWLHIN, the Health Care Connect program has improved their connection rate from 73.9 per cent to 91.3 per cent.
Share leading practices to improve availability of same day appointments, after-hours availability, telehomecare and home visits.	More residents have access to same-day appointments and after hours care thanks to a commitment from all Family Health Teams, Community Health Centres, and nurse practitioner-led clinics to provide this care where appropriate for their patients. This last year, there were 5,000 more care appointments through telemedicine than last year. Since the launch of central intake, 10,000 more people with diabetes are accessing education and support services.
Expand the centralized intake process for diabetes services to the remainder of the WWLHIN.	The WWLHIN was the first in the province to implement centralized intake for diabetes care. As a result, referrals for diabetes care have increased by more than 50 per cent and wait times for diabetes programs have been reduced.
Identify opportunities to expand successes in diabetes coordination model to support people with other chronic diseases.	Planning has begun on the expansion of central intake to improve chronic disease prevention and management in other areas. A physician lead for chronic disease prevention and management was also created to support this work.
Develop a Centre of Excellence for eHealth to lead initiatives including: • Increasing the adoption and use of Clinical Connect. • Supporting clinicians to use their Electronic Medical Records (EMRs) to improve quality, access to care and health service planning. • Ensuring primary care providers receive timely information when their patients go to the hospital, and leave the hospital including a discharge summary and list of medications.	A centre of excellence for eHealth was developed at the Centre for Family Medicine Family Health Team in Kitchener. Over the past year, expanded use of Clinical Connect exceeded the target with more than 1,300 new users across the LHIN. The WWLHIN was also the first in the province to expand the use of electronic health records to public health units, long-term care, midwifery, and a nurse practitioner-led clinic. This has allowed the more timely sharing of clinical information between care providers – helping them to better understand the needs of the resident, improving the care experience for the resident, making more informed decisions, and improving health outcomes.

PRIORITY: Creating a More Seamless and Coordinated Health Care Experience

The goal: To create a seamless experience of care so people have better health outcomes and get the right care, in the right place, at the right time. And to ensure support for those with the most complex health care needs.

What is seamless and coordinated care? Seamless care occurs when patients transition from health provider to health provider without needing to repeat their story – knowing that all their health care providers have the same knowledge about their unique health care needs. Coordinated care means people always know where to go and it's easy to find the help they need.

Why is this important? A young man – we'll call him Tony – had been struggling with substance abuse. He also required care for a mental health concern. He lost his job and was on the verge of homelessness. He didn't know where to go for help so he called multiple places and got tired of telling people why he needed help. He gave up. If Tony had experienced coordinated care, he would have made one phone call and been referred for the care he needed.

Progress: Over the past year, providers have been better connected, making it easier for residents to access the care they need. One of the areas of greatest need for improvement was in addictions and mental health. Too many residents were "falling through the cracks", not knowing where to go for help, and having trouble navigating a complex system of providers who each held a piece of the care puzzle.

GOING HOME... STAYING HOME

When Jarvis took over his father's real estate business in 1955, he never imagined he would be faced with selling his own home to move to long-term care. Yet, as Jarvis and his wife Linda began to notice problems with his memory, remaining at home seemed unmanageable.

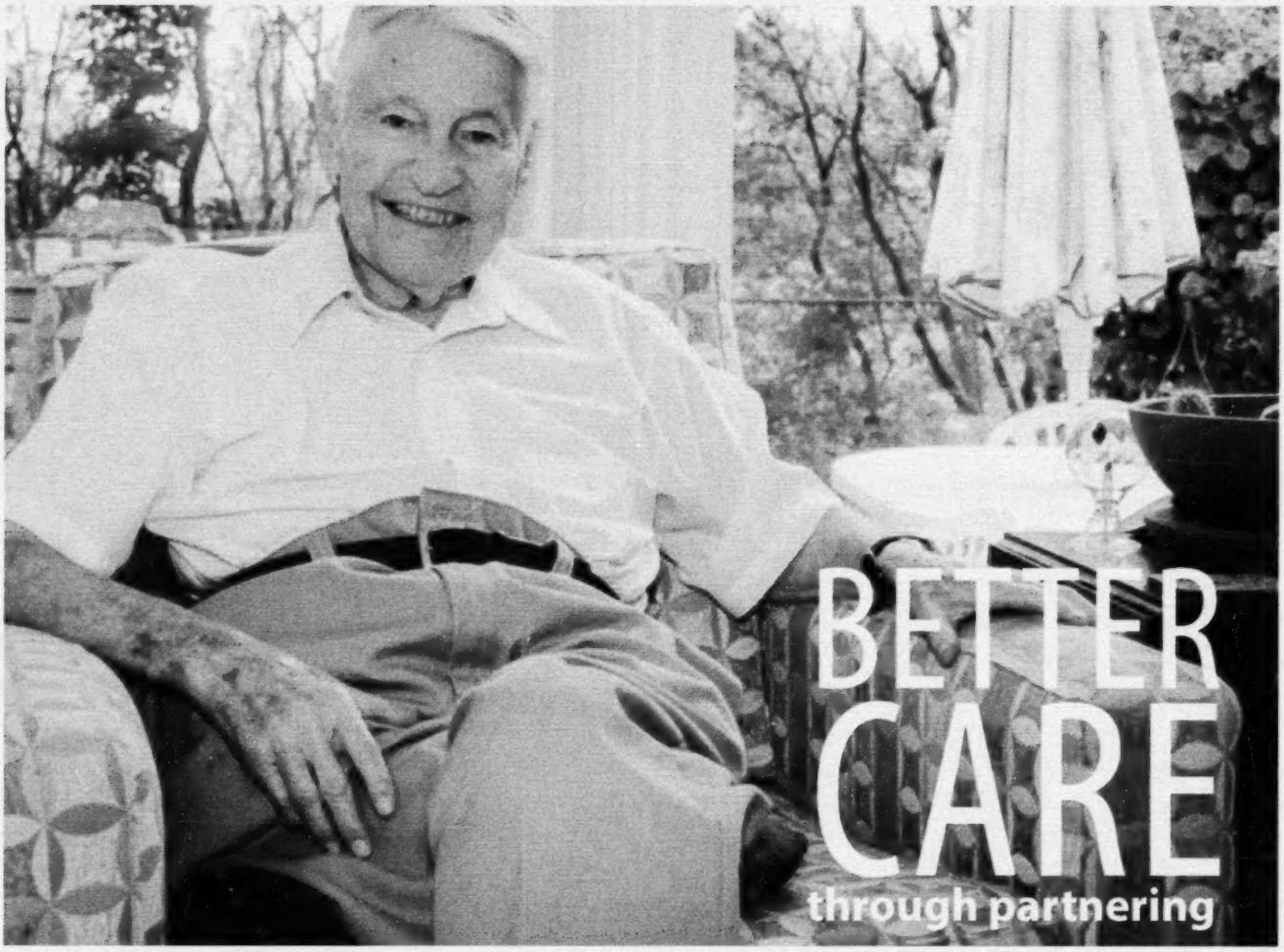
The health system swung into action when Linda called 911 to assist Jarvis after he had a fall. Jarvis found himself in an ambulance, on his way to Grand River Hospital, where it was determined that a medication interaction led to his disorientation and fall.

When he was admitted to hospital, the hospital team and the Integrated Discharge Planner (staff shared by Grand River Hospital and the Waterloo Wellington Community Care Access Centre) began planning for a safe return home. From Linda's point of view she saw a team of professionals working quickly and effectively. "The nurses and doctors worked together to help Jarvis and gave us hope he would return safely home," says Linda.

"Our Integrated Discharge planning process is a truly collaborative model that highlights the need for the acute and community sectors to be working side-by-side," said Malcolm Maxwell, CEO Grand River Hospital. "There is no hand-off because the discharge planning has been a joint effort right from admission to hospital."

As Jarvis's condition stabilized, the CCAC worked with providers to coordinate an enhanced plan for home care services to support Jarvis when he arrived at home. A wrap-around service plan that could include up to 24 hours per day was developed to ensure Jarvis could recuperate and return to independence.

Within just two weeks of discharge, Jarvis was improving and regaining his independence enough to be cared for with normal levels of personal support. Jarvis's recovery was so successful that it wasn't long before they decided the application to long-term care



was no longer needed. Linda credits the personal support workers for helping Jarvis achieve his independence goals. "It's like having a family member or friend stop by to help out every day," explains Linda, noting that Jarvis's care and well-being is a true partnership between personal support workers, CCAC, Linda, and Jarvis himself.

Within a few weeks, Jarvis was ready to try a community Adult Day Program. In combination with ongoing service from the CCAC, the support provides stimulation and socialization for Jarvis and caregiver respite for Linda.

Jarvis remains quite active around the house and goes for short walks outside most days. "I just don't know what we would have done without all the help from so many places," Linda says, "I can't put a price on the difference it has made."

Jarvis

THEN

Residents had to stay in hospital while waiting for home care.

NOW

Wait times for home care after hospital discharge have been reduced by 66%, allowing residents to go home faster.

HAVE YOU SEEN THE CHILDREN?

Helen spent most of her life caring for others. When she was diagnosed with Alzheimer's in 2009, the roles were reversed and she found herself being cared for in long-term care.

Helen would usually start to get anxious during the evening hours and was often seen walking around with her walker telling anyone she saw that she was looking for the children.

"Have you seen the children? Do you know where the children are? I've lost the children."

At first staff tried reality orientation, assuring Helen that there were no children here and that she lived in long-term care. When that did not settle her, they tried telling Helen that the children were at home with their mother or were in bed sleeping.

"As Helen's dementia progressed, her search for the children became a great source of distress for her," said one of her caregivers. "We tried to reassure her and redirect her attention but this seemed to upset her more. It was also upsetting the other residents."

It was at this time that the new Behavioral Supports (BSO) Team was asked to get involved. The BSO Team provides specialized care for seniors in long-term care who have challenging mental health, dementia, and other neurological conditions (concerns affecting the brain, spine, and nerves).

Because Helen was looking for the children, the BSO Team thought they would try giving her a doll and see how she responded. Her daughter Mary was given information about doll therapy and agreed to trial this as a care strategy.

"Helen was given one of our beautiful weighted dolls which looked to be about three-months-old. Helen loved her doll. It soon became her constant companion and she stopped looking for the children and was much more relaxed and happy. She even took the doll home with her for a Christmas visit to her daughters and upon her return, her daughter shared some photographs with the staff. All of Helen's gifts were doll items: clothes, blankets and even a beautiful new coat for the doll," said her caregiver.

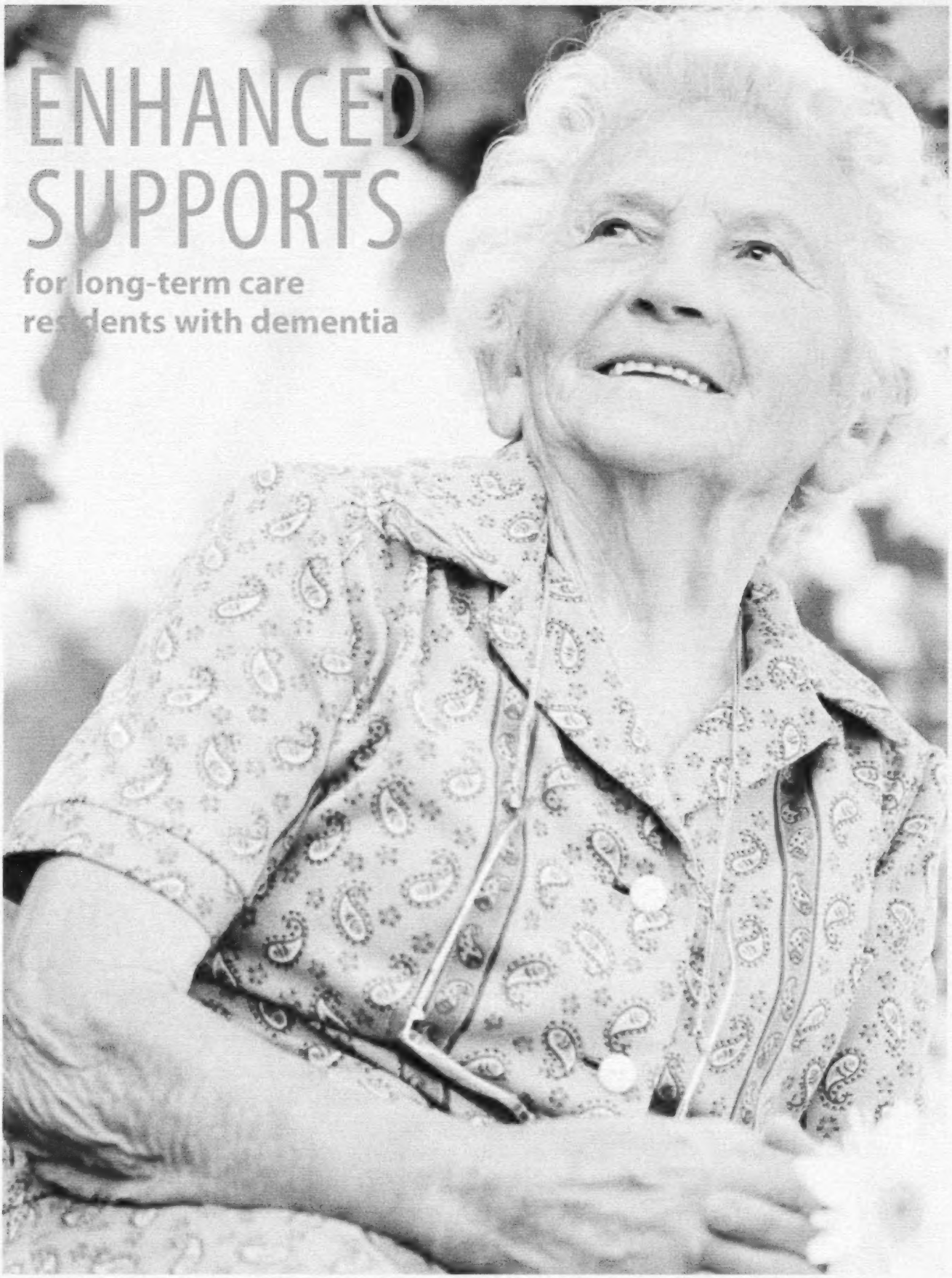
After Helen passed away, staff learned that over the course of Helen's life, she had been a foster mom to 72 children. This was the reason that this doll had brought such a great comfort to Helen in the last months of her life. She was able to continue caring for others, even while she received her own care.

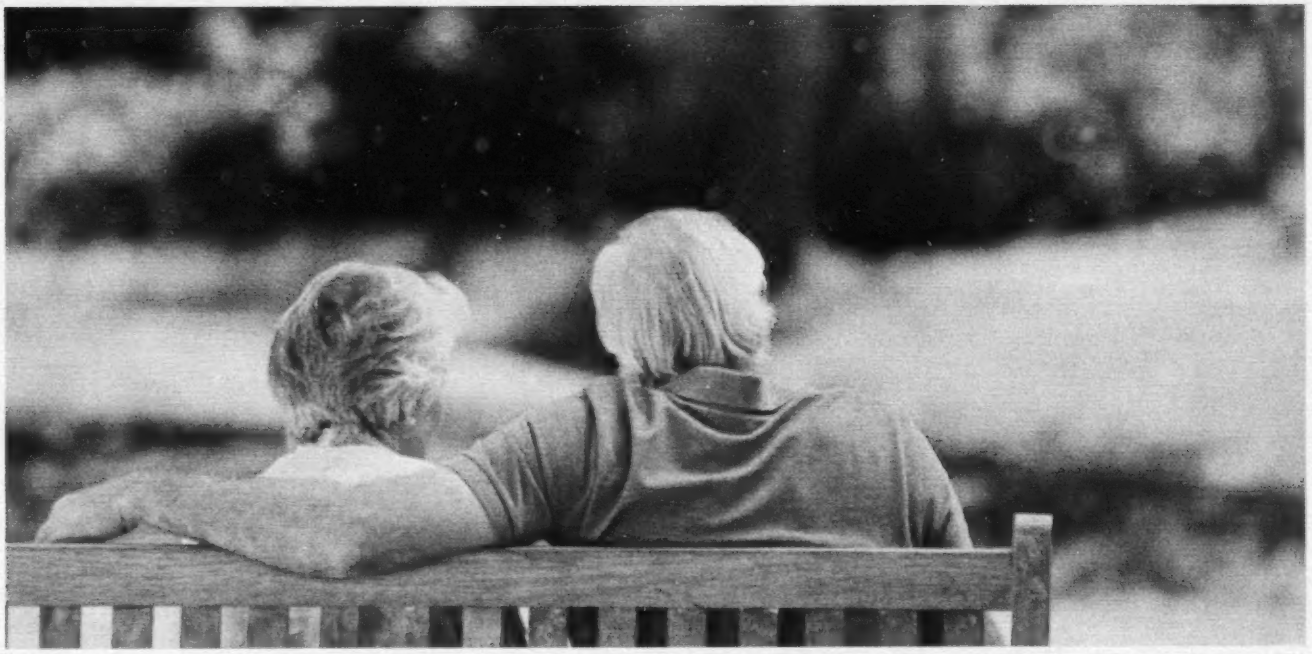
THEN

Residents in long-term care needed care in the emergency department due to falls and other health issues.

NOW

Long-term care homes in Waterloo Wellington have the lowest rate of falls resulting in ED visits in the province.


ENHANCED
SUPPORTS
for long-term care
residents with dementia



MAKING THE UNBEARABLE MORE BEARABLE

Listening to Emmy speak, you'd never know the loss she has been through. She is incredibly passionate, an active volunteer, and a positive light for many losing a loved one of their own.

"In March of 2012, my wonderful husband Eric came to Hospice Wellington. His almost three-year struggle with colon cancer was coming to an end. Nothing more could be done, other than to keep him comfortable," she said.

The decision for Eric to live his final days at Hospice was an easy one for them. Eric had been President of the Guelph Rotary Club when they were working hard to raise money for the Hospice. "I remember saying to him, Honey – now you're going to be able to enjoy some of the fruits of your labours."

THEN

Many residents needed to live in long-term care after a hospitalization because the right supports weren't available in the community.

NOW

Almost 40% fewer residents need to go to long-term care after hospitalization.

Emmy felt comfortable knowing Eric was being well cared for. "Hospice made a dreadfully sad time more bearable. Not only did they give Eric compassionate care, but they also offered tremendous support to our family as we came and went over the three weeks that he was here. I could go home at night knowing Eric would be resting comfortably, and if I felt like being with him in the middle of the night, I could show up at the door at 3 a.m. and be welcomed."

Emmy describes the Hospice staff as uplifting and inspiring to her and Eric. As a volunteer, she is the one now inspiring so many others as they struggle to find the positive in a very difficult time. "I can't say enough in praise of Hospice Wellington. Bless all the people who worked so hard over the years to make it possible, and those who continue to work every day to provide extraordinary care."

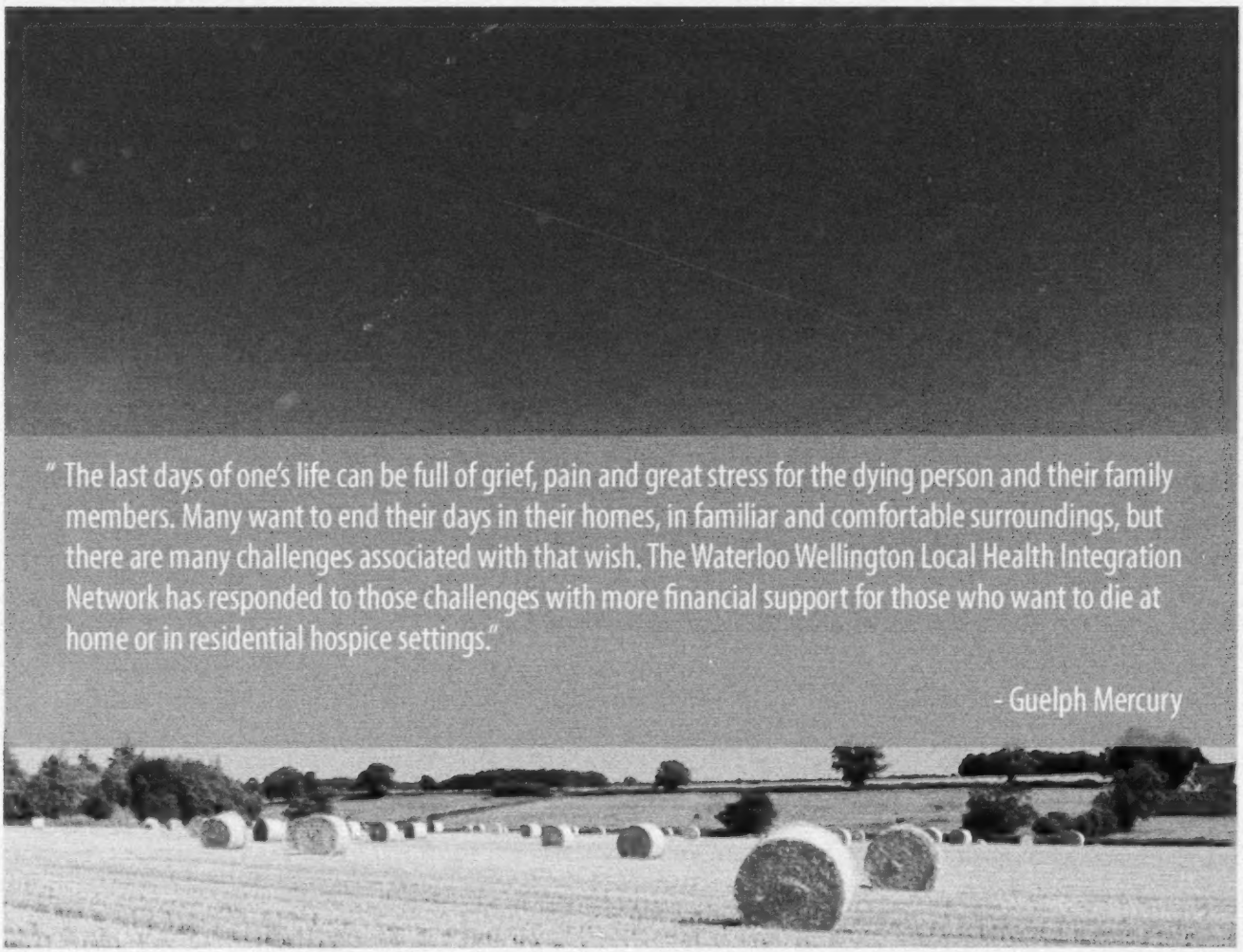
Emmy

EXPANDED END-OF-LIFE CARE SUPPORTS FAMILIES

After listening to residents and providers talk about the need for better access to palliative (end-of-life) care, the WWLHIN acted to improve this care for residents and their families across Waterloo Wellington.

In the past year, integration took place to transfer pain and symptom management programs from the Waterloo Wellington Community Care Access Centre (WWCCAC) to Hospice Waterloo. This program provides education, mentorship, and clinical advice to health care providers who are not palliative care specialists, including in long-term care, across the WWLHIN. As a result of the integration, better outcomes were achieved for residents and families through an increase in consultations to providers, improved coordination, and a single standard approach.

Additional integrations took place, including resource sharing between Hospice Waterloo Region and Hospice Wellington, and a joint day program. The WWLHIN also announced an additional $1 million in funding for palliative care in home and community settings such as hospice.


" The last days of one's life can be full of grief, pain and great stress for the dying person and their family members. Many want to end their days in their homes, in familiar and comfortable surroundings, but there are many challenges associated with that wish. The Waterloo Wellington Local Health Integration Network has responded to those challenges with more financial support for those who want to die at home or in residential hospice settings."
- Guelph Mercury

KEY STATISTICS AND ADDITIONAL HIGHLIGHTS

INTRODUCING "HERE 24/7"

A significant accomplishment this past year was the launch of "Here 24/7", a coordinated approach for addictions and mental health care with "one front-door". Now residents can call one number whenever they need help and they will be connected with the best provider to assist them. This program is the first of its kind in Ontario.

HERE 24 SEVEN

Call anytime to access Addictions, Mental Health & Crisis Services

Waterloo · Wellington · Dufferin

1 844 437 3247 (HERE247)

THEN
Residents and health care providers had to contact many different agencies to access the care needed.
NOW
Access to diabetes, addictions & mental health, and community care has been simplified to either one form or one phone number for referral.

Centralized access to respite care through the Waterloo Wellington CCAC and expansion of the program to operate **7 DAYS A WEEK.**

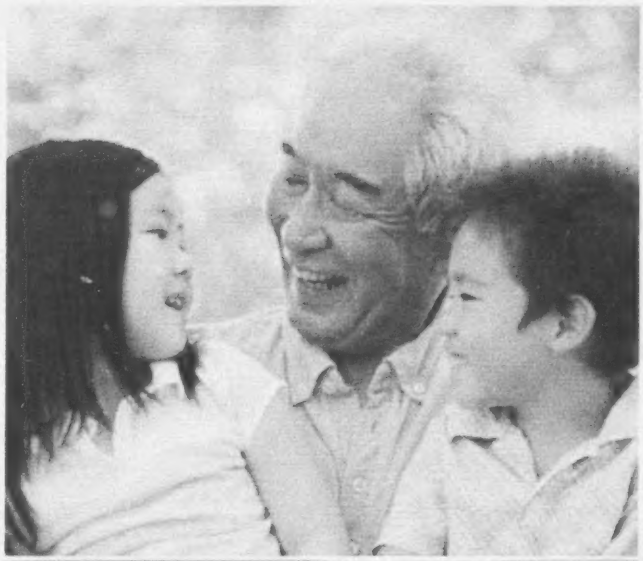
Integration of the **ALZHEIMER SOCIETIES** of Kitchener-Waterloo, Cambridge, and Guelph-Wellington to create a new Alzheimer Society of Waterloo Wellington. This has improved coordination of programs and increased the number of residents the agency serves.

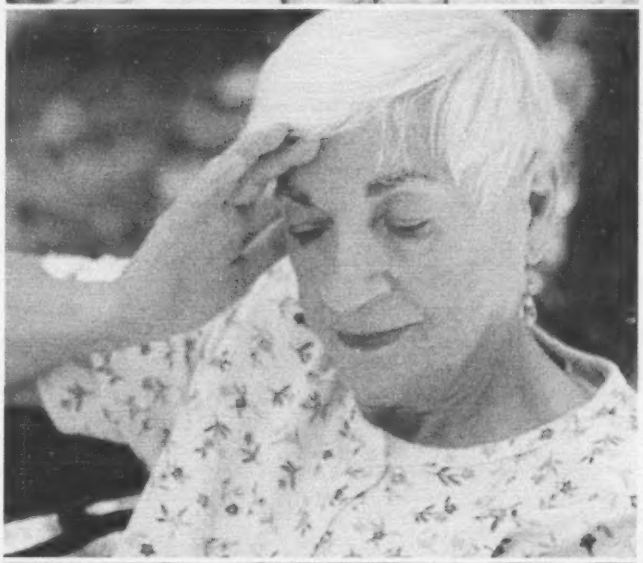
MORE THAN 60,000 people will access information and services through the new "Here 24/7" each year.

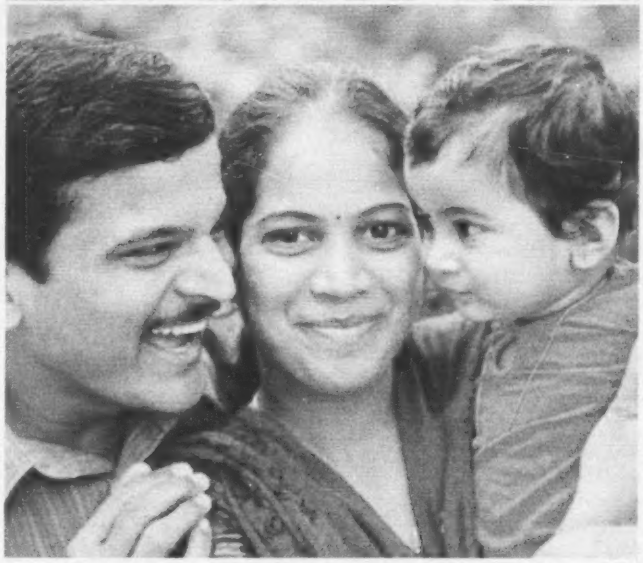
296 MORE long-term care beds across Waterloo Wellington.

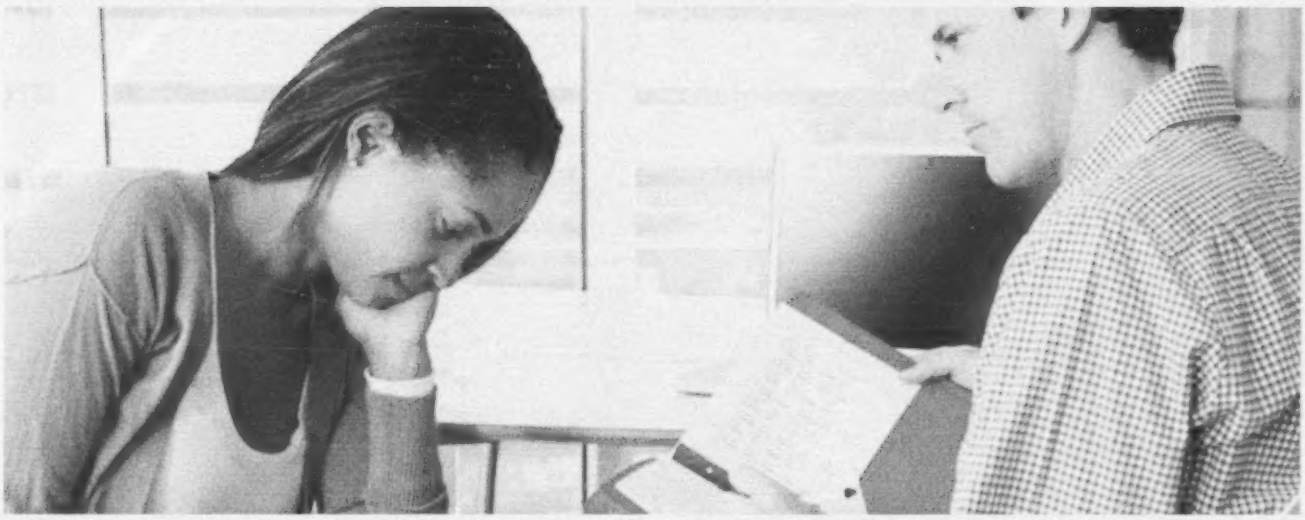
17,326 HOSPITAL ALC DAYS SAVED through Home First since April 2011. $7.8 M re-invested in hospital care.

ALC = patients waiting for the right care in the right place.









CREATING A MORE SEAMLESS & COORDINATED HEALTH CARE EXPERIENCE - PERFORMANCE REPORT

Residents across Waterloo Wellington have easier access to care thanks to achievements in creating a more seamless and coordinated health care experience.

The percentage of residents waiting in hospital for care in a more appropriate place (alternate level of care) was reduced to 11.5 per cent – closer to the target of 9.5 per cent and an almost 50 per cent improvement since tracking of this indicator began. Readmission rates for certain medical conditions – a key indicator of quality of care – dropped to 14.3 per cent, almost at the target of 14 per cent.

There was an increase this past year in readmission rates for addictions and mental health conditions as a result of a number of challenges identified in supporting residents with complex addictions and mental health issues. The introduction of Here 24/7, along with increased funding for support coordination and improvements being made to Assertive Community Treatment Teams (ACT) will improve care for these residents over the next year.

Increases in the number of clients served and the complexity of the health needs of those clients resulted in an increase in wait times for Waterloo Wellington CCAC clients. In the fall of 2013, the WWLHIN invested more than $12 million in new funding in the community sector. As a result of this and enhanced partnerships with community support services, the wait time for WWCCAC services was reduced by 77 per cent over the past year.

PERFORMANCE INDICATOR	System Starting Point*	Local System Target	Most Recent Local System Performance	LHIN Rank
Acute ALC Days Best Cared For In Another Setting**	20.1%	9.5%	11.5%	4
Readmissions to Hospital for Certain Medical Conditions	15.6%	14.0%	14.3%	1
Readmissions to Emergency for Mental Health Conditions	15.4%	13.2%	15%	N/A[2]
Readmissions to Emergency for Substance Abuse	20.4%	18.1%	20%	N/A[2]
Wait Time for Community Residents - CCAC Application to First Assessment[1]	-	5	4	1
Wait Time for Community Residents - CCAC First Assessment to First Service[1]	-	13	14	N/A[2]
Wait Time for Hospital Patients - From Discharge to CCAC First Service[1]	-	5	5	2

Legend

Note 1: Indicators of Emergency Room Stay and Wait Times represent the experience of the 9th person out of 10 people tracked. In other words, 8 other people had lower wait times than this number and one had a higher wait time.

Note 2: Data not yet reported

* Starting Point: Performance prior to LHIN or first available data point after creation of LHIN

**ALC: Alternate Level of Care

SPECIFIC 2013-14 INITIATIVES AND RESULTS

GOAL	ACHIEVEMENT
Integrate hospice palliative care services across sectors and providers.	Pain and symptom management programs were transferred from the Waterloo Wellington Community Care Access Centre (WWCCAC) to Hospice Waterloo. As a result of the integration, better outcomes were achieved for residents and families through an increase in consultation service to providers, improved coordination, and a single standard approach. Additional integrations took place, including resource sharing between Hospice Waterloo Region and Hospice Wellington, and operation of a joint day program.
Complete the implementation of the Acquired Brain Injury (ABI) integration plan.	At Traverse Independence, all one-time outreach clients have been served, and all targets were met or exceeded. Transitional Living has transitioned 20 clients this year with an average length of stay of one year – reducing ALC days in hospital and helping more residents access the hospital care they need. The nurse practitioner specialized ABI services completed their first full year of service and ABI specialized training was provided to 500 professionals in the Waterloo Wellington area.
Implement an integrated regional program for Adult Day Programs, including a standardized model of service based on best practice.	The Waterloo Wellington LHIN provided one-time funding to the Adult Day Services sponsor organization, the Region of Waterloo (Sunnyside Seniors' Services) in November 2013 to support the development and implementation of an integrated program model for all Adult Day Services across the WWLHIN. As a result, residents across Waterloo Wellington will have access to the same standard of care with the same core services.
Implement integrations of addictions and mental health services with consideration to the recommendations of the Support Coordination Review, Assertive Community Treatment Teams Review and Addictions Services Review.	Local providers of support coordination have developed a model of "clusters" of care. Each "cluster" is an interdisciplinary team, working together to provide the most appropriate level of assessment and case management possible for residents. In October 2013, the WWLHIN Board of Directors approved new funding for an addictions support coordination team under the leadership of Stonehenge Therapeutic Community. In December 2013, Dr. Ian Musgrave, a recognized ACT model expert was retained to complete an evaluation of the local ACT teams. The teams are now working to implement the report recommendations, as well as on a plan to "step-down" residents to a more appropriate level of service once their condition has improved.
Implement coordinated access for addictions and mental health services.	Coordinated access for addictions and mental health "Here 24/7" was launched in April – the first of its kind in Ontario.
Continue to pursue service and back office integrations to improve client experience, health outcomes and value for money in all sectors.	The four local Community Health Centres entered into a shared service agreement to leverage their resources to enhance and better manage their information technology infrastructure. This has enabled them to engage a higher level of technical expertise, extend help desk support, and consolidate software/hardware systems. The integration of the four Alzheimer Societies into one resulted in the integration of all back-office and technology services to better support residents.
Ensure residents get the right care in the community based on the complexity of their needs by defining and adjusting WWCCAC and Community Support Services functions	In the fall of 2013, the WWLHIN allocated over $12 million in new incremental base funding to support investments in the community sector. As a result, wait times for home-care for community residents were reduced and the target was met. A new screening tool was also implemented to ensure residents with less complex needs are being served by community support services.
Improve access to short-stay transitional and respite beds.	Convalescent or "recovery" care at Sunnyside Home in Kitchener was expanded from 10 to 25 beds. Access to respite care was centralized though the Waterloo Wellington CCAC and the program was expanded to operate seven days a week.
Develop opportunities to further enhance the WWLHIN Long-term Care environments such as through specialized behavioural care.	Specialized behavioural supports are available in all 35 long-term care homes and in the community through a community responsive behaviours team. Further integration of this program was completed over the past year with clinical intake, a collaborative community team, Health Links, and the use of telemedicine.
Identify duplication and streamline system navigation services, freeing up capacity in the system to support more frail elderly.	Implementation of an integrated system of care for frail seniors in Waterloo Wellington has resulted in increased integration, seamless navigation and improved coordination of services for frail seniors that supports client choice. A nurse practitioner wait list management support has resulted in an over 50 per cent reduction in wait times and priority urgent referrals are responded to by a geriatrician within 24-72 hours.

PRIORITY: Leading a Quality Health Care System Using Evidence-based Practice

The goal: To identify and use evidence-based practice to redesign our health system, ensuring quality care and better health outcomes.

What is quality health care? Quality health care means that the care people receive is: safe, effective, accessible, equitable, efficient, sensitive to their needs, integrated, appropriately resourced, and focused on preventing illness as much as treating illness.

One way we improve quality is by connecting programs and services through what is officially termed integration. Integration is about ensuring the same standard of care is provided in all locations, and improving the patient experience. This way, no matter where a family lives, or who they are, they receive the same quality care.

Why is this important? Two women both had a stroke – we'll call them Betty and Anne. Betty received care in a dedicated stroke unit with specialized care. Anne received general care. Betty recovered faster and went home with enhanced home-care support. Anne spent more time in hospital, and was slower to regain her mobility. By improving quality of care through integration and implementing evidence-based practice, both Betty and Anne would have received the same care and both would have had a better chance of recovering more fully, and more quickly.

Progress: Over the past year, local residents have benefited from collaborative efforts to integrate health care programs and improve quality of care.

EASING DAILY STRUGGLES

Living with diabetes can be a daily struggle for many residents. When you couple that with dementia, the situation is even more difficult.

When Paul, a 65-year-old man from Aberfoyle, was diagnosed with mild dementia five years ago he had trouble remembering to take his blood tests and often forgot to take his insulin.

During the fall of 2013, Paul's dementia began to progress very quickly and his wife Sue was finding it difficult to make sure he was eating the right foods, taking his medication, and following all of the directions of his care team.

"Around Christmas last year, I came home from shopping and found Paul on the floor in our kitchen," said Sue. "He didn't know where he was, he was having trouble breathing and all he kept saying was that his stomach hurt."

Sue called 911 and Paul was rushed to the hospital where he was diagnosed with diabetes ketoacidosis – a serious condition caused by a shortage of insulin. During Paul's stay at the hospital, Sue explained to staff that she was not able to manage Paul's care alone anymore and that she would need to move him into a long-term care home. The team at the hospital explained a new wrap-around care approach called Health Links, that would help Paul get care from various providers through a coordinated plan.

"All of a sudden, we had all of these services to help us," said Sue. "Paul started receiving additional support for his diabetes, he went to a memory clinic, and he also started going to Adult Day Programs."

Because of the development of a coordinated referral process for diabetes care, as an urgent case, Paul was able to access diabetes programs within two days. As part of his Health Links team, the Waterloo Wellington Community Care Access Centre (CCAC) determined that Paul required more home care and he now receives visits by the regional in-home teams, as well as daily personal support worker (PSW) services.

"I had no idea these people were available to help us. I didn't have to call around. The best part was that they all got to know us and helped us to make a plan that would help me to keep Paul at home. I don't feel alone anymore and I feel like I always know who to call if I get overwhelmed again," Sue said.

Not only did Paul benefit from coordinated care, as a result of evidence-based care and enhanced community supports, he hasn't needed to be readmitted to hospital. This means better health for Paul and better access to care for other residents needing hospital services.

THEN

Standardized vehicles for measuring patient satisfaction did not exist.

NOW

More health service providers are using standard measurement tools – St. Mary's General Hospital is rated among the top 10% of Ontario's hospitals for patient satisfaction.

REDUCED EMERGENCY DEPARTMENT WAIT TIMES IN WATERLOO WELLINGTON

Waiting for care is frustrating and difficult. Fortunately, over the past five years significant progress has been made to reduce wait times.

"When the LHINs were created, this region had some of the longest wait times for non-urgent CT and MRI exams, cardiac and cataract surgeries, and hip replacements. These wait times have decreased by almost as much as 80 per cent," said Bruce Lauckner, CEO, WWLHIN.

Emergency department (ED) wait times were also a concern. This past year, Waterloo Wellington celebrated the shortest ED wait times in Ontario for patients with complex care needs requiring admission to hospital. Also, wait times for all patients who visited the ED were the lowest ever recorded in Waterloo Wellington, since ED wait time tracking started in 2008.

Emergency department wait times are measured by what is called 'length of stay'. This is the total amount of time a patient spends in the emergency department from the time they are triaged to the time they either go home or are transferred for further care elsewhere. This time includes examinations, blood work, diagnostic testing, diagnosis, treatment, and more.

Patients needing to be admitted to hospital are now spending a total of 17.3 hours in the ED, compared to 29 hours five years ago. Residents with complex conditions but not needing admission to hospital are seen and treated within 6.6 hours (below the provincial target and now one hour less than before) and for patients with uncomplicated care needs, who don't need to be admitted to hospital, the length of stay was reduced by 22 per cent to 4.3 hours. Despite seeing more residents overall, and more residents with complex care needs, wait times as a whole are improving.

The WWLHIN invested significantly in community supports to help keep people healthy in their homes, worked with community partners to improve access to primary care to prevent avoidable emergency department visits, and worked with local hospitals to support them in finding innovative ways to provide care for more people, more efficiently.

"Working with the Waterloo Wellington LHIN, partners across the health system, and front-line ED staff has allowed us to treat more people, with more complex health issues, in less time," said Dr. Ian Digby, Chief of Emergency Medicine at Guelph General Hospital and Emergency Department Care Lead for the WWLHIN. "The ability to move a senior with complex health issues into a hospital bed faster, means better care for that senior and a shorter wait time for a woman with stomach pain or a child with flu-like symptoms."

SHORTER WAIT TIMES (Improved by*)

Emergency department stay for admitted patients: Down 40.3%	↓ 11.7 HRS
Non-urgent MRIs: Down 68.8%	↓ 154 DAYS
Non-urgent CT scans: Down 78.8%	↓ 104 DAYS
Hip replacements: Down 62.7%	↓ 262 DAYS
Cardiac by-pass surgery: Down 78.8%	↓ 115 DAYS

**This reflects improvements from the system starting point, i.e. when measurement started.*

KEY STATISTICS AND ADDITIONAL HIGHLIGHTS

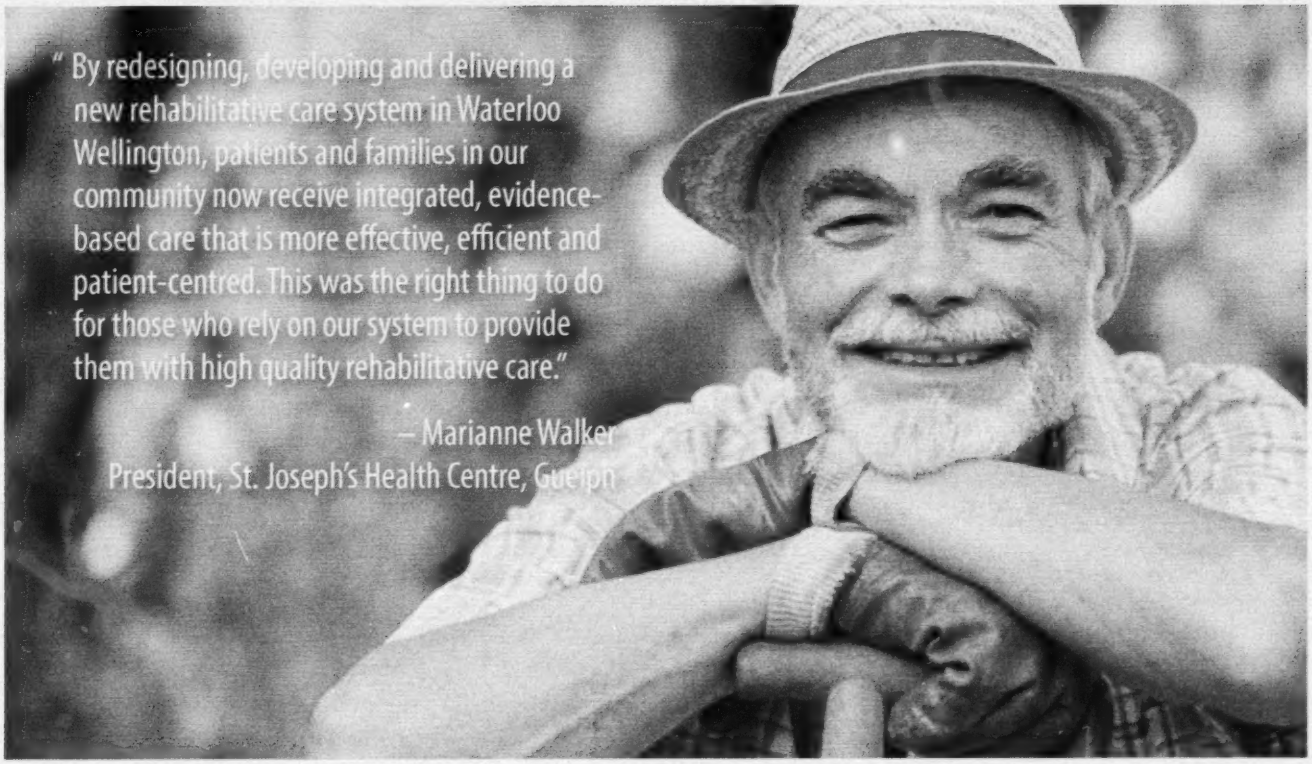
INTEGRATED STROKE AND REHABILITATION CARE

Because of the implementation of a regional integrated program for stroke care, 20 more residents will survive an initial stroke every year, fewer residents will experience serious debilitation from a stroke, and as many as 100 more residents will return home after a stroke rather than go to long-term care. This improvement was achieved by clustering stroke care in two centres of excellence where residents can benefit from specialized care and expertise.

A new integrated program for rehabilitative care was also implemented. In 2011, a comprehensive review of rehabilitative care in Waterloo Wellington revealed a number of issues affecting access and quality of care including the need for standardized best practices across the LHIN and the need for integration between providers to better support those transitioning between different care settings. Residents now have access to four streams of rehabilitative care that support patients from hospital to rehab and in the community.

Work has also begun on planning for the creation of integrated programs in critical care, surgery, pharmacy, and cardiac care.

THEN
Waterloo Wellington hospitals had a higher than expected mortality rate.
NOW
The mortality rate in local hospitals is lower than any of the provincial and national averages.


" By redesigning, developing and delivering a new rehabilitative care system in Waterloo Wellington, patients and families in our community now receive integrated, evidence-based care that is more effective, efficient and patient-centred. This was the right thing to do for those who rely on our system to provide them with high quality rehabilitative care."
– Marianne Walker
President, St. Joseph's Health Centre, Guelph

As many as

100 MORE RESIDENTS

will return home after a stroke rather than going to long-term care.

In 2007, the WWLHIN had an HSMR of 127.5 – now the

HSMR LOCALLY IS 75.8

(which is lower than the national average)

One measure of quality of care in hospital is the Hospital Standardized Mortality Ratio or HSMR. The ratio compares the mortality rate of hospitals with the average national experience to show how hospitals are doing.

464,016 LESS HOURS

waited in the emergency department for care.

A "LIFE OR LIMB"

policy was brought into effect across Waterloo Wellington. This includes a "no refusal" policy, meaning that all hospitals will work together to provide hospital care for residents whose life or a limb is at risk.

LEADING A QUALITY HEALTH CARE SYSTEM USING EVIDENCE-BASED PRACTICE - PERFORMANCE REPORT

Improving quality is a key priority for the Waterloo Wellington LHIN and an important gauge of success in all areas of health system improvement. Current measures of quality include: patient satisfaction; wait times; readmission rates to hospital; and incidences of mortality.

Wait times in Waterloo Wellington are up to 80 per cent lower than they were when wait times were first measured. Waterloo Wellington has the lowest wait times for cardiac surgery in the province and has remained the provincial leader in moving patients into hospital beds quickly from the emergency department. While MRI wait times are not currently meeting the 28-day target, they are 75 per cent lower than when first measured. Waterloo Wellington also has a lower hospital standardized mortality ratio (HSMR) than any of the provincial and national averages.

Readmission rates to hospital for stroke patients continues to be an area of focus. While rates have increased over the past year, the launch of a new integrated stroke program based on evidence-based best practices will improve the quality of stroke care residents receive across Waterloo Wellington.

With a new standard provincial measure of patient satisfaction, the Waterloo Wellington LHIN will also have better data to measure its performance in improving the patient experience in hospitals and across the health system.

PERFORMANCE INDICATOR	System Starting Point*	Local System Target	Most Recent Local System Performance	LHIN Rank
Emergency Room Stay for Admitted Patients[1]	29.0	8.00	17.3	1
Emergency Room Stay for Complicated Conditions[1]	7.7	7.00	6.6	6
Emergency Room Stay for Uncomplicated Conditions[1]	5.5	4.00	4.3	10
Wait Times for MRI (non-emergent)[1]	224.0	28	70	10
Wait Times for CT Scan (non-emergent)[1]	132.0	28	28	6
Wait Times for Hip Replacement (non-emergent)[1]	418.0	166	156	5
Wait Times for Knee Replacement (non-emergent)[1]	447.0	166	256	10
Wait Times for Cancer Surgery (non-emergent)[1]	68.0	49	49	7
Wait Times for Cataract Surgery (non-emergent)[1]	274.0	166	143	6
Wait Times for Cardiac By-Pass Surgery (non-emergent)[1]	146.0	42	18	1
Hospital Standardized Mortality Ratio	127.5	100.0	75.8	N/A
Readmissions to Hospital for Stroke Patients (per 100 patients)	6.6%	6.0%	8.0%	3

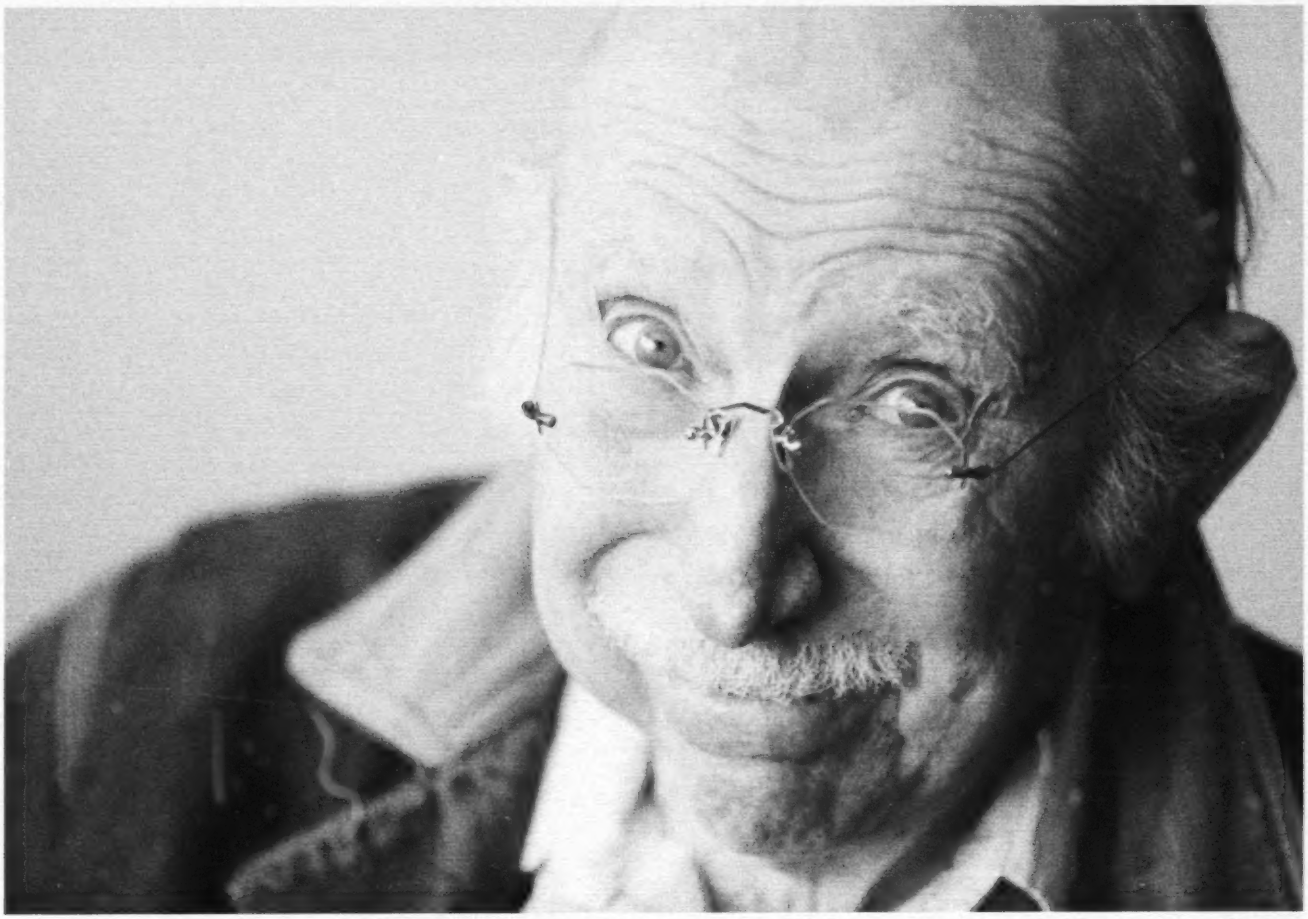
Legend

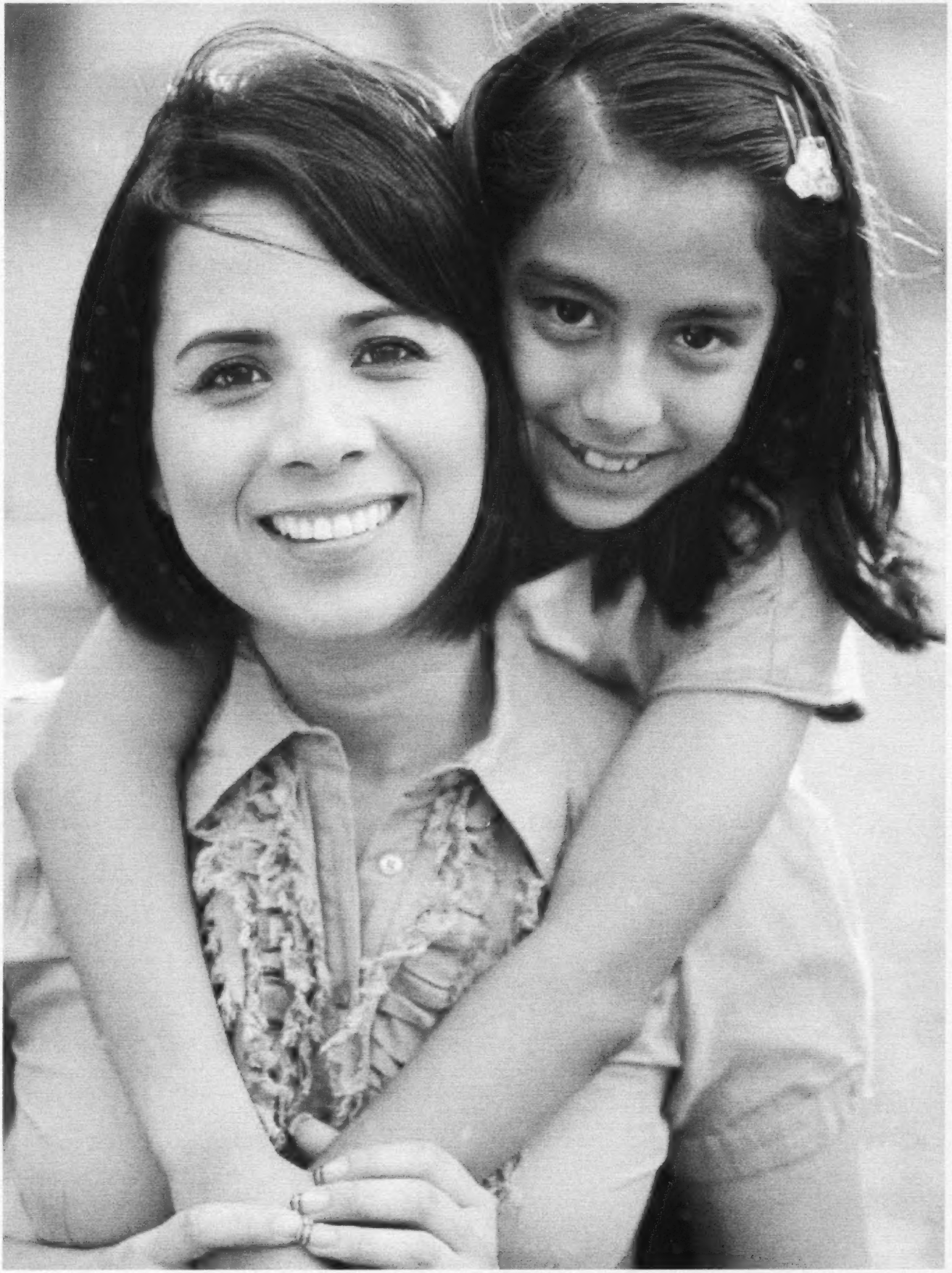
Note 1: Indicators of Emergency Room Stay and Wait Times represent the experience of the 9th person out of 10 people tracked. In other words, 8 other people had lower wait times than this number and one had a higher wait time.

* Starting Point: Performance prior to LHIN or first available data point after creation of LHIN

In addition to lowering wait times, the WWLHIN is also focusing on ensuring a high percentage of residents receive care within the recommended or "target" time frame. Below are new targets the WWLHIN and local health service providers are committed to and current progress. Despite these new indicators being introduced part way through the year, we have already made improvements in each area where we had not yet achieved the target.

PERFORMANCE INDICATOR	2013-14 Starting Point	Local System Target	Most Recent Local System Performance	LHIN Rank
Percent of non-emergent cases completed within access target (84 days) for cancer surgery	99.00%	90.00%	94.09%	9
Percent of non-emergent cases completed within access target (90 days) for cardiac by-pass surgery	99.60%	90.00%	100%	1
Percent of non-emergent cases completed within access target (182 days) for cataract surgery	99.00%	90.00%	98.12%	5
Percent of non-emergent cases completed within access target (182 days) for hip replacement	82.00%	90.00%	93.59%	6
Percent of non-emergent cases completed within access target (182 days) for knee replacement	67.00%	90.00%	79.44%	7
Percent of non-emergent cases completed within access target (28 days) for MRI scans	55.00%	90.00%	64.41%	5
Percent of non-emergent cases completed within access target (28 days) for CT scans	83.00%	90.00%	83.54%	5





SPECIFIC 2013-14 INITIATIVES AND RESULTS

GOAL	ACHIEVEMENT
Develop a Local Quality Partnership to bring local clinical and system leaders together to improve the quality of local care.	The establishment of the Waterloo Wellington Local Quality Partnership (WW LQP) has brought together local clinical and system leaders on a monthly basis to advise the WWLHIN on how best to foster and support a change management environment that is focused on attaining quality improvements for local patients and residents.
Improve the quality of services through the roll out of quality based procedures.	Quality of care is being improved for local residents through the development of integrated programs with a focus on the implementation of quality based procedures specifically for surgical procedures.
Implement the regional integrated program for stroke care which will include the establishment of a dedicated acute stroke unit and specialized rehabilitation services.	Because of the implementation of a regional integrated program for stroke care, 20 more residents will survive an initial stroke every year, fewer residents will experience serious debilitation from a stroke, and as many as 100 more residents will return home after a stroke rather than go to long-term care. This was achieved by clustering stroke care in two centres of excellence where residents can benefit from specialized care and expertise.
Complete the next phase of implementation for a regional program for rehabilitative care which will include care pathways based on best practices implemented consistently across the WWLHIN.	A new integrated program for rehabilitative care was implemented. Residents now have access to four streams of rehabilitative care that support patients from hospital to rehab and in the community.
Implement six new regional clinical programs which will include the establishment of a program sponsor and clinical councils for each program, identification of standards and care pathways, and a move towards more equitable access and consistency of quality across Waterloo Wellington: Addictions and mental health; cardiac; critical care with an initial focus on closed access ICUs; emergency; pharmacy, starting with anti-microbial stewardship; and surgery , with an initial focus on Quality-Based Procedures (QBPs) Each regional program council will establish standards, monitor key metrics and make system improvements within the program.	Program sponsors and clinical councils have been established for each regional clinical program. The councils are currently evaluating current practices, identifying areas for improvement, and developing a plan for moving forward. Planning is also occurring for the roll-out of quality based procedures and the implementation of health system funding reform. In each area we look forward to achieving the same great results we have seen in cardiac and cancer care, now two of the best programs in the province.
Implement an integrated wound management program across the continuum of care.	The first phase of the program was completed this year including establishing a Wound Care Council which completed a current state assessment, future state model, implementation plan, and sustainability plan. This program will decrease the prevalence of avoidable wounds and improve wound care across the continuum of care.
Implement the provincial life or limb policy across Waterloo Wellington.	A life or limb policy was brought into effect across Waterloo Wellington. This "no refusal" policy means that all hospitals have committed to work together to provide timely hospital care for residents whose life or a limb is at risk. Previously, when a hospital was full or access to a specialist was unavailable, residents might wait longer for care. Now residents will receive faster care and have a greater chance of recovery.
The WWLHIN will continue to hold providers accountable through the HSAA for meeting standards set both by the province and locally.	The WWLHIN is meeting or exceeding many of its Ministry-LHIN Performance Agreement targets, and is a provincial leader in a number of key areas. More detail is available in the performance reports under each priority.

ENGAGING OUR COMMUNITY

WHAT IS COMMUNITY ENGAGEMENT?

As local residents, the staff of the Waterloo Wellington LHIN are deeply rooted within the communities they serve. This local perspective, coupled with formal and informal community engagement, provides the WWLHIN with a strong understanding of the unique needs of residents across Waterloo Wellington.

This is important because improvements to the health system must directly reflect the needs of local residents. To fully understand what those needs are, the WWLHIN engages residents to inform, educate, consult, involve and empower them to participate in the planning and decision-making processes that will improve the local health system.

What does all of that really mean? It means that the WWLHIN talks to residents and stakeholders before making decisions. It also means that if residents or stakeholders have concerns or ideas about improving the health system in Waterloo Wellington, the WWLHIN is here to listen.

What community engagement does not mean is that everyone will always agree on the decisions that are made within the health system. Waterloo Wellington is made up of a diverse population of people with very different interests and approaches to what health care is and how to improve it. What the WWLHIN does is listen to all of those different opinions and incorporate them into the decision-making process.

ENGAGEMENT OPPORTUNITIES IN 2013-14

Throughout the past year, the WWLHIN formally and informally engaged thousands of residents and health care workers.

Through the roll-out of the new Integrated Health Service Plan (IHSP), development of the 2014–15 Annual Business Plan, community events, network and council meetings, news conferences, Board meetings, community outreach, and more, the WWLHIN Board of Directors and staff were regularly meeting and talking with stakeholders and community members.

Specifically, the WWLHIN focused its engagement efforts on the following key stakeholders:

Local Residents

Our residents and families are at the heart of our strategy to improve access, service and quality within our local health care system. Residents were engaged through our 15-member Community Council, community events, one-on-one meetings, through health service providers, and more. The perspectives of local residents are central to every decision made by the WWLHIN Board and staff.

Our Local Health Service Providers

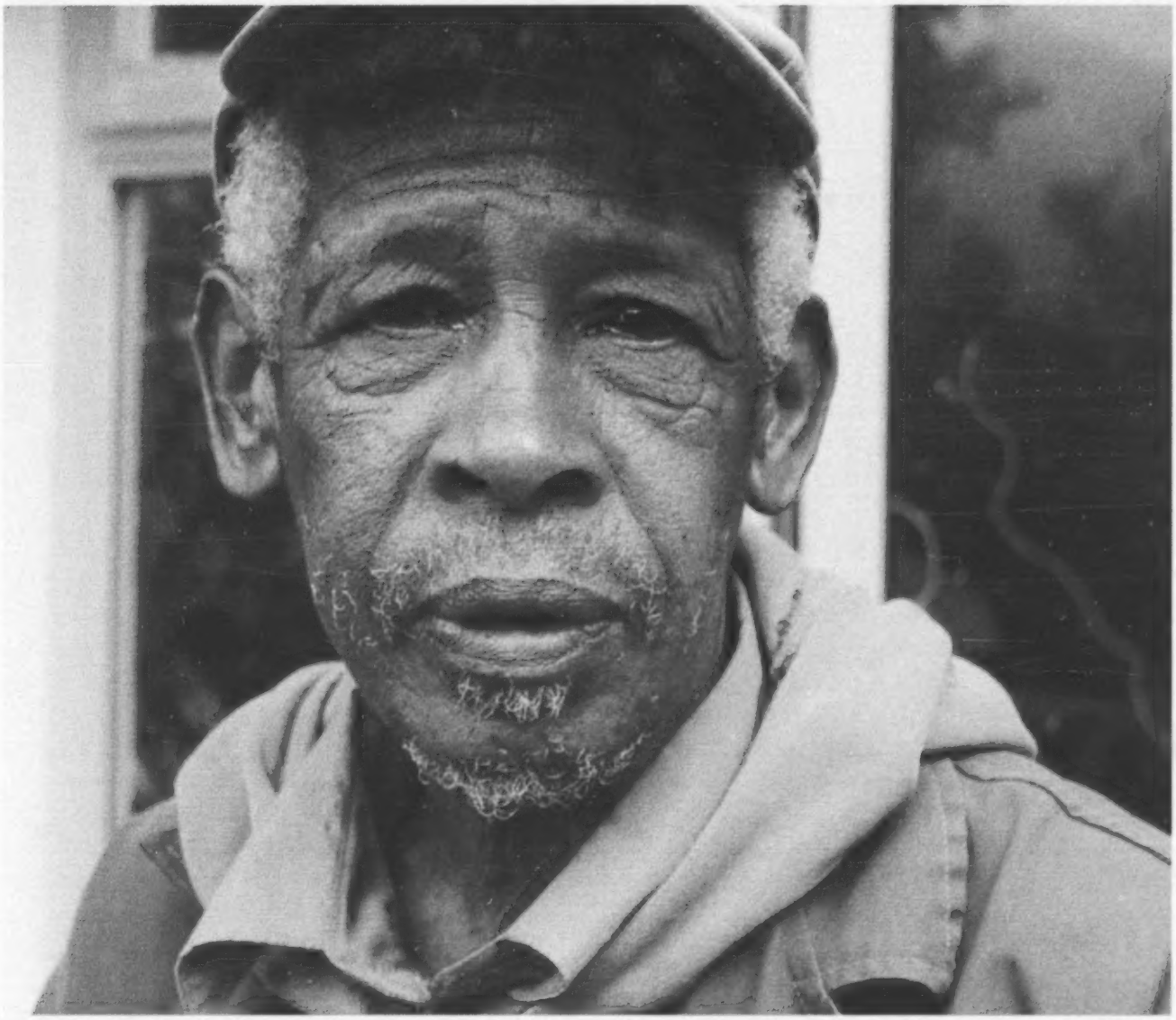
Health service providers are the nuts and bolts of our health system. Together, they provide essential services dedicated to improving the health and well-being of our residents. They are also responsible for the implementation of our system's strategic plan, the IHSP. While engagement with health system leaders and front-line staff continued with the development of the 2014-15 Annual Business Plan, a specific emphasis was placed this year on engaging health system governors. Many board-to-board meetings took place, as well as planning for a governor engagement strategy and hosting of governor symposia to advance integration by encouraging governance collaboration.

Local Organizations

Social determinants of health are the socio-economic, cultural, and environmental conditions of our lives that impact overall health. No one sector or organization can fully improve the health of the population alone. This is why it is so important for the WWLHIN to engage individuals and organizations outside of the health care sector. This year, focus was placed on engaging the broader public sector and community organizations to better support residents through Health Links and connectivity tables or hubs. As a result of these efforts, organizations are now wrapping health and social services around residents most in need – looking beyond the scope of their own service to ensure residents receive the right supports in the community. Waterloo Wellington is quickly becoming a provincial leader in this area.

WWLHIN Advisory Groups and Local Provider Networks

Advisory Groups and Networks are one of the unique ways the WWLHIN has brought health service providers together, working towards a common goal – improving the health and well-being of residents. This past year, the WWLHIN worked with its advisory groups and networks on the integration of various programs and services, including: rehabilitation and stroke, diabetes care, addictions and mental health, and more. These groups included: Local Health Professionals Advisory Council, Primary Care Advisory Council, and various networks (Addictions and Mental Health, Community Support Services, Geriatric Services, Emergency Services, etc.).



FRENCH LANGUAGE COMMUNITY ENGAGEMENT & HEALTH SERVICES

The French-speaking community of Waterloo Wellington includes an increasingly culturally diverse population, as new immigrants make up the majority of new French-speaking people in our region. Specific data on the increase of French-speaking residents in our area is not readily available since the last census did not use Ontario's definition of 'French-speaking'; however, across Ontario, the French-speaking population increased 6 per cent over the data from 2006. The most recent data suggests that there are approximately 10,500 residents in Waterloo Wellington who identify French as their first language and over 15,000 who have knowledge of French and speak French at home (this includes many recent immigrants).

With the support of a survey on the health status of the French-speaking in our community, done by our region's French Language Health Planning Entity (Entité2), alongside the results of the WWLHIN's survey, we were able to engage with, identify, and respond to some of the health care needs expressed as priorities by our local French speaking community.

As a result, this year the WWLHIN implemented a number of health services in French, including mental health services through telemedicine, and French-speaking primary care through Family Health Teams.

ABORIGINAL PLANNING ACTIVITIES & HEALTH SERVICES

The local Aboriginal community in Waterloo Wellington is entirely urban based. There are no reserve lands or Indian Friendship Centres within our boundaries. Aboriginal residents who need health care either access services from the local mainstream health system, or they travel outside of the WWLHIN to access culturally appropriate care. The diversity of our Aboriginal population makes it a challenge to connect with the full local Aboriginal community, however this year we engaged through two specific initiatives that have improved engagement and access to health services for Aboriginals in the WWLHIN:

First, a new health and wellness program was established for the Aboriginal community at the Kitchener Downtown Community Health Centre, and a Health and Wellness promoter was hired to create a link between the Aboriginal community and health service providers in Waterloo Wellington.

Secondly, the Hospice Waterloo completed a Palliative Care Needs Assessment for the Aboriginal community, funded by the WWLHIN and informed by more than 60 people from the Aboriginal community in Waterloo Wellington. The project was also linked with an initiative at Cancer Care Ontario which is focused on developing an Ontario-wide palliative care strategy for the Aboriginal community.

This year, the Waterloo Wellington LHIN was also actively involved in advancing cultural competency work with staff, our Board of Directors, and with health service providers across the local health system. The WWLHIN hosted workshops delivered by a seasoned Aboriginal facilitator for all staff and Board members. The workshops were also offered to health and community agencies across our LHIN, and over 92 per cent of all WWLHIN health service providers participated in the workshops. Very positive feedback was provided after the workshop, and we are in the process of developing a strategy to continue the learning process, both at the LHIN and for all health service providers.

Standard meetings with the Ministry of Child and Youth Services and the Ministry of Community and Social Services were also established this fiscal year. This new partnership will help ensure that services developed or adapted for the Aboriginal community are consistent with their needs and are culturally appropriate. This will also help to coordinate a comprehensive approach to services for the Aboriginal community. Through these planning sessions, we are also establishing partnerships between these organizations and key providers of health services in our LHIN to facilitate the continuum of care. As a result of this collaboration, MCYS clients now have improved access to services through telemedicine.

WWLHIN OPERATIONS

Total revenue for 2013-14 includes funding for WWLHIN operations and initiatives, and funding for health service providers in accordance with public sector reporting guidelines.

In 2013-14, the WWLHIN operational budget was $4.6 million plus $1.5 million in special initiatives funding. Funding provided to health service providers totalled $1.022 billion. Approximately half of one per cent of our total funding is used for WWLHIN operations to support the important roles of health system oversight, performance management, funding, planning, coordinating, integrating and improving our local health system.

The WWLHIN ended the fiscal year with an operational surplus of $478,506. The WWLHIN had a staff complement of 30 full time equivalent (FTE) positions focused on improving quality outcomes, access to care, and value for taxpayer dollars. Our full-time and contracted staff have diverse skill sets and backgrounds and include nurses, allied health professionals and former executives from large health service providers, government and private sector organizations, our Primary Care Physician Lead, Emergency Department Physician Lead, Critical Care Physician Lead, and Chronic Disease Prevention and Management Lead.

The audited financial statements follow on page 45.

LOOKING AHEAD: THE THOMAS FAMILY

As we reflect on the past year, we also look to the year ahead. The first year of the WWLHIN's three-year Integrated Health Service Plan (IHSP) built exciting momentum for change. Entering into year two, the path ahead is clear.

Work will continue on Health Links to better support residents with complex needs. Work will continue to better connect services and improve navigation – through central intake for chronic disease management and others – and integration work will continue to ensure residents have access to high-quality care regardless of where they live in our community.

For a complete look at what the more than 37,000 health care workers across Waterloo Wellington are committed to achieving this coming year, read the WWLHIN's 2014–15 Annual Plan. Here you will be introduced to the Thomas family and their experience with the changes in the local health system this far. You'll also learn about how the changes over the next year will provide better care for the Thomas's and the thousands of families like them across Waterloo Wellington.

MANAGEMENT RESPONSIBILITY REPORT

The management of the Waterloo Wellington Local Health Integration Network (LHIN) is responsible for preparing the accompanying financial statements in conformity with generally accepted accounting principles. In preparing these financial statements, management selects appropriate accounting policies and uses its judgement and best estimates to report events and transactions as they occur. Management has determined such amounts on a reasonable basis in order to ensure that the financial statements are presented fairly, in all material respects. Financial data included throughout this Annual Report is prepared on a basis consistent with that of the financial statements.

The LHIN maintains a system of internal accounting controls designed to provide reasonable assurance, at a reasonable cost, that assets are safeguarded and that transactions are executed and recorded in accordance with the LHIN's policies for doing business.

The Board of Directors is responsible for ensuring that management fulfills its responsibility for financial reporting and internal control, and is ultimately responsible for reviewing and approving the financial statements. The Board carries out this responsibility principally through its Audit Committee. The Committee meets approximately four times annually to review audited and unaudited financial information. Deloitte & Touche LLP has full and free access to the Audit Committee.

Management acknowledges its responsibility to provide financial information that is representative of the LHIN's operations, is consistent and reliable, and is relevant for the informed evaluation of the LHIN's activities.

Bruce Lauckner
Chief Executive Officer

Mr. Matthew Little, CPA, CMA, MBA
Chief Financial Officer

June 26, 2014

Financial statements of

Waterloo Wellington Local Health Integration Network

March 31, 2014

Waterloo Wellington Local Health Integration Network

March 31, 2014

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Independent Auditor's Report

To the Members of the Board of Directors of the
Waterloo Wellington Local Health Integration Network

We have audited the accompanying financial statements of Waterloo Wellington Local Health Integration Network, which comprise the statement of financial position as at March 31, 2014, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Waterloo Wellington Local Health Integration Network as at March 31, 2014 and the results of its operations, change in its net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
June 26, 2014

Waterloo Wellington Local Health Integration Network

Statement of financial position as at March 31, 2014

	2014	2013
	$	$
Financial assets		
Cash	**844,942**	962,598
Due from Ministry of Health and Long-Term Care (Note 9)	**2,378,472**	-
Other receivables	**124,090**	56,131
	3,347,504	1,018,729
Liabilities		
Accounts payable and accrued liabilities	**667,663**	673,075
Due to Ministry of Health and Long-Term Care (Note 3b)	**334,506**	369,847
Due to Health Service Providers ("HSPs") (Note 9)	**2,378,472**	-
Due to the Local Health Integration Networks Shared Services Office (Note 4)	**89**	35,450
Deferred capital contributions (Note 5)	**252,488**	281,354
	3,633,218	1,359,726
Net debt	**(285,714)**	(340,997)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	**33,226**	59,643
Tangible capital assets (Note 7)	**252,488**	281,354
	285,714	340,997
Accumulated surplus	**-**	-

Approved by the Board

John S. Fisle

Board Chair

Finance and Audit Committee Chair

The accompanying notes to the financial statements are an integral part of this financial statement.

Waterloo Wellington Local Health Integration Network

Statement of operations
year ended March 31, 2014

	Budget (Note 8)	2014 Actual	2013 Actual
	$	$	$
Revenue			
Ministry of Health and Long-Term Care funding			
Health Service Providers transfer payments (Note 9)	**1,000,603,795**	**1,021,950,105**	996,284,176
Local Health Integration Network operations - general and administrative	**5,540,003**	**5,515,079**	4,377,108
Enabling Technologies ETI PMO (Note 10a)	**-**	**280,000**	580,000
Emergency Department Lead (Note 10b)	**75,000**	**75,000**	75,000
Emergency Department/Alternative Levels of Care Lead (Note 10c)	**100,000**	**100,000**	100,000
Aboriginal Planning (Note 10d)	**5,000**	**5,000**	5,000
French Language Services (Note 10e)	**106,000**	**106,000**	106,000
Critical Care Lead (Note 10f)	**75,000**	**75,000**	75,000
Primary Care Lead (Note 10g)	**75,000**	**75,000**	75,000
Amortization of deferred capital contributions (Note 5)	**75,000**	**81,134**	88,663
	1,006,654,798	**1,028,262,318**	1,001,765,947
Funding repayable to Ministry of Health and Long-Term Care (Note 3b)	**-**	**(478,506)**	(369,847)
	1,006,654,798	**1,027,783,812**	1,001,396,100
Expenses			
Transfer payments to Health Service Providers (Note 9)	**1,000,603,795**	**1,021,950,105**	996,284,176
Local Health Integration Network operations - general and administrative (Note 11)	**5,615,003**	**5,241,802**	4,396,348
Enabling Technologies ETI PMO (Note 10a)	**-**	**171,752**	282,399
Emergency Department Lead (Note 10b)	**75,000**	**66,661**	75,000
Emergency Department/Alternative Levels Levels of Care Lead (Note 10c)	**100,000**	**100,000**	100,000
Aboriginal Planning (Note 10d)	**5,000**	**360**	5,000
French Language Services (Note 10e)	**106,000**	**106,000**	106,000
Critical Care Lead (Note 10f)	**75,000**	**72,132**	72,435
Primary Care Lead (Note 10g)	**75,000**	**75,000**	74,742
	1,006,654,798	**1,027,783,812**	1,001,396,100
Annual surplus and accumulated surplus, end of year	**-**	**-**	-

The accompanying notes to the financial statements are an integral part of this financial statement.

Waterloo Wellington Local Health Integration Network

Statement of change in net debt
year ended March 31, 2014

	Budget (Note 8)	2014	2013
	$	$	$
Annual surplus	-	-	-
Change in prepaid expenses, net	**35,000**	**26,417**	(32,212)
Acquisition of tangible capital assets	**(50,000)**	**(52,268)**	(81,825)
Amortization of tangible capital assets	**75,000**	**81,134**	88,663
Decrease (increase) in net debt	**60,000**	**55,283**	(25,374)
Net debt, beginning of year	**(340,997)**	**(340,997)**	(315,623)
Net debt, end of year	**(280,997)**	**(285,714)**	(340,997)

The accompanying notes to the financial statements are an integral part of this financial statement.

Waterloo Wellington Local Health Integration Network

Statement of cash flows
year ended March 31, 2014

	2014	2013
	$	$
Operating activities		
Annual surplus	-	-
Less: items not affecting cash		
Amortization of tangible capital assets	**81,134**	88,663
Amortization of deferred capital contributions (Note 5)	**(81,134)**	(88,663)
	-	-
Changes in non-cash operating items		
Increase in due from Ministry of Health and Long-Term Care	**(2,378,472)**	-
(Increase) decrease in other receivables	**(67,959)**	192,209
Decrease in accounts payable and accrued liabilities	**(5,412)**	(61,541)
(Decrease) increase in due to Ministry of Health and Long-Term Care	**(35,341)**	268,368
Increase in due to Health Service Providers ("HSPs")	**2,378,472**	-
Decrease in due to eHealth Ontario	-	(1,660)
(Decrease) increase in due to Local Health Integration Networks Shared Services Office	**(35,361)**	35,450
Decrease (increase) in prepaid expenses	**26,417**	(32,212)
	(117,656)	400,614
Acquisition of tangible capital assets	**(52,268)**	(81,825)
Financing activity		
Capital contributions received (Note 5)	**52,268**	81,825
Net (decrease) increase in cash	**(117,656)**	400,614
Cash, beginning of year	**962,598**	561,984
Cash, end of year	**844,942**	962,598

The accompanying notes to the financial statements are an integral part of this financial statement.

Waterloo Wellington Local Health Integration Network

Notes to the financial statements
March 31, 2014

1. Description of business

The Waterloo Wellington Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Waterloo Wellington Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers all of the County of Wellington, the Region of Waterloo, and the City of Guelph. The LHIN also contains part of Grey County, which is split with the South West and the North Simcoe Muskoka LHINs. The LHIN enters into service accountability agreements with health service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ('MOHLTC") and provides the framework for the LHIN accountabilities and activities. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Service Providers ("HSPs"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSPs' Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

Commencing April 1, 2007, all funding payments to LHIN managed HSPs in a LHIN geographic area, have flowed through each LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in each LHIN's financial statements for the year ended March 31, 2014.

The LHIN statements do not include any Ministry managed programs.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian Public Sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable. Through the accrual basis of accounting, expenses include non-cash items such as the amortization of tangible capital assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the statement of operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment, furniture and fixtures	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment	5 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year.

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of operations and within the related notes for both the prior and current year sufficiently disclose information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimates and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Funding received	Eligible expenses	2014 Funding excess	2013 Funding excess
	$	$	$	$
Transfer payments to HSPs	**1,021,950,105**	**1,021,950,105**	**-**	-
LHIN operations	**5,596,213**	**5,241,802**	**354,411**	69,423
Enabling Technologies	**280,000**	**171,752**	**108,248**	297,601
Critical Care Lead	**75,000**	**72,132**	**2,868**	2,565
Emergency Department Lead	**75,000**	**66,661**	**8,339**	-
Emergency Department/Alternative Levels of Care Lead	**100,000**	**100,000**	**-**	-
Aboriginal Planning	**5,000**	**360**	**4,640**	-
French Language Services	**106,000**	**106,000**	**-**	-
Primary Care Lead	**75,000**	**75,000**	**-**	258
	1,028,262,318	**1,027,783,812**	**478,506**	369,847

b) The amount due to the MOHLTC at March 31 is made up as follows:

	2014	2013
	$	$
Due to MOHLTC, beginning of year	**369,847**	101,479
Paid to MOHLTC during year	**(513,847)**	(101,479)
Funding repayable to the MOHLTC related to current year activities (Note 3a)	**478,506**	369,847
Due to MOHLTC, end of year	**334,506**	369,847

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all the LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at the year end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all the LHINs.

4. Related party transactions (continued)

The LHINC was formed in fiscal 2011 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC is to support the LHINs in:

- Fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system;
- Their role as system manager;
- Where appropriate, the consistent implementation of provincial strategy and initiatives;
- The identification and dissemination of best practices.

LHINC is a LHIN-led organization and accountable to the LHINs. LHINC is funded by the LHINs with support from the MOHLTC.

5. Deferred capital contributions

	2014	2013
	$	$
Balance, beginning of year	**281,354**	288,192
Capital contributions received during the year	**52,268**	81,825
Amortization for the year	**(81,134)**	(88,663)
	252,488	281,354

6. Commitments

The LHIN has commitments under various operating leases and maintenance contracts related to building, software and equipment. Lease renewals are likely. Minimum lease payments due in each of the next five years are as follows:

	$
2015	535,237
2016	334,501
2017	311,380
2018	311,380
2019	311,380
Thereafter	389,225

The LHIN also has funding commitments to HSPs associated with accountability agreements. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

7. Tangible capital assets

	Cost	Accumulated amortization	2014 Net book value	2013 Net book value
	$	$	$	$
Office equipment, furniture and fixtures	358,356	301,878	56,478	82,690
Computer equipment	82,117	78,678	3,439	6,878
Leasehold improvements	274,529	81,958	192,571	191,786
	715,002	462,514	252,488	281,354

8. Budget figures

The budget figures reported in the statement of operations reflect the initial budget at April 1, 2013 as approved by the LHIN Board. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $1,021,950,105 is derived as follows:

	$
Initial budget	1,000,603,795
Additional funding received during the year	21,346,310
Final budget	1,021,950,105

The final LHIN general and administrative and specific initiatives budget of $6,087,079 is derived as follows:

	$
Initial budget	5,976,003
Additional funding received during the year	163,344
Amount treated as capital contributions made during the year	(52,268)
Final budget	6,087,079

No budget was set for items appearing on the statement of change in net debt.

9. Transfer payments to HSPs

During the year the LHIN was authorized to allocate funding of $1,021,950,105 (2013 - $997,730,993) to the various HSPs in its geographic area. Year-end adjustments initiated by the MOHLTC resulted in a reduction of transfer payments totalling $Nil (2013 - $1,446,757) resulting in total transfer payments recorded of $1,021,950,105 (2013 - $996,284,176). Actual transfer payments to the various sectors in fiscal 2014 as follows:

	2014	2013
	$	$
Operations of hospitals	**592,553,624**	593,412,581
Grants to compensate for municipal taxation - public hospitals	**159,225**	159,225
Long-Term care homes	**176,901,625**	167,134,986
Community care access centre	**122,436,308**	116,841,644
Community support services	**25,334,972**	20,925,843
Assisted living services in supportive housing	**5,923,778**	5,871,978
Community health centres	**20,799,606**	17,275,279
Community mental health programs	**36,660,812**	33,617,670
Specialty psychiatric hospitals	**30,642,050**	30,642,050
Addictions programs	**10,538,105**	10,402,920
	1,021,950,105	996,284,176

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2014, an amount of $2,378,472 (2013 - $Nil) was receivable from the MOHLTC and payable to HSPs. These amounts have been reflected as revenue and expenses in the statement of operations and are included in the table above.

10. Separate funding amounts were received by the LHIN from the MOHLTC for specific initiatives

a) Enabling Technologies for Integration Project Management Office

Effective January 31, 2014, the LHIN entered into an agreement with Erie St. Clair, Hamilton Niagara Haldimand Brant and South West (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

For 2014, the MOHLTC provided the South West LHIN with $2,320,000 related to Enabling Technologies initiatives. The South West LHIN flowed $280,000 of the cash to the Waterloo Wellington LHIN.

The LHIN's financial statements reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses.

10. Separate funding amounts were received by the LHIN from the MOHLTC for specific initiatives (continued)

a) Enabling Technologies for Integration Project Management Office (continued)

The following provides condensed financial information:

		2014	2013
	Total	LHIN's portion	LHIN's portion
	$	$	$
Revenue	**2,320,000**	**280,000**	580,000
Expenses	**1,951,019**	**171,752**	282,399
Accumulated surplus	**368,981**	**108,248**	297,601

Expenses incurred by the LHIN are:

	2014	2013
	$	$
Salaries, benefits and consulting services	**171,752**	251,433
Other	**-**	30,966
	171,752	282,399

The Waterloo Wellington LHIN has included the unspent portion of its share of funding of $108,248 as due to the MOHLTC. These funds will be transferred to the South West LHIN who in turn will repay amounts to the MOHLTC.

b) Emergency Department Lead

The LHIN received funding of $75,000 (2013 - $75,000) related to the Emergency Department Lead. Emergency Department Lead expenses incurred during the year are as follows:

	2014	2013
	$	$
Salaries, benefits and consulting services	**62,500**	72,000
Other	**4,161**	3,000
	66,661	75,000

c) Emergency Department/Alternative Levels of Care Lead

The LHIN received funding of $100,000 (2013 - $100,000) related to the Emergency Department/Alternative Levels of Care Lead. Emergency Department/Alternative Levels of Care Lead expenses incurred during the year are as follows:

	2014	2013
	$	$
Salaries, benefits and consulting services	**100,000**	100,000

10. Separate funding amounts were received by the LHIN from the MOHLTC for specific initiatives (continued)

d) Aboriginal Planning

The LHIN received funding of $5,000 (2013 - $5,000) related to Aboriginal Planning. Aboriginal Planning expenses incurred during the year are as follows:

	2014	2013
	$	$
Community engagement	**360**	5,000

e) French Language Services

The LHIN received funding of $106,000 (2013 - $106,000) related to French Language Services. French Language Services expenses incurred during the year are as follows:

	2014	2013
	$	$
Salaries, benefits and consulting services	**84,394**	81,412
Other	**21,606**	24,588
	106,000	106,000

f) Critical Care Lead

The LHIN received funding of $75,000 (2013 - $75,000) related to Critical Care Lead. Critical Care Lead expenses incurred during the year are as follows:

	2014	2013
	$	$
Salaries, benefits and consulting services	**72,000**	72,000
Other	**132**	435
	72,132	72,435

g) Primary Care Lead

The LHIN received funding of $75,000 (2013 - $75,000) related to the Primary Care Lead. Primary Care Lead expenses incurred during the year are as follows:

	2014	2013
	$	$
Salaries, benefits and consulting services	**73,788**	72,000
Other	**1,212**	2,742
	75,000	74,742

11. LHIN operations - general and administrative expenses

The statement of operations presents expenses by function. The following classifies general and administrative expenses by object:

	2014	2013
	$	$
Salaries and benefits	**3,636,724**	2,986,664
Occupancy	**303,894**	292,973
Amortization	**81,134**	88,663
Shared Services	**391,006**	359,858
LHIN Collaborative	**47,500**	47,500
Public relations	**64,204**	89,293
Consulting services	**148,791**	89,377
Supplies	**48,721**	35,018
Board Chair per diems	**66,500**	73,475
All other board members' per diems	**34,925**	39,175
Other governance costs	**36,247**	57,913
Mail, courier and telecommunications	**42,628**	45,274
Other	**339,528**	191,165
	5,241,802	4,396,348

Diabetes Regional Coordination Centres

The LHIN received funding of $1,341,284 (2013 - $260,214), which is included in the operating expenses of the LHIN, related to the assumption of work plan deliverables for diabetes and chronic disease management planning effective February 1, 2013. Expenses incurred of $1,030,667(2013 - $197,234) are included in general and administrative expenses in the statement of operations and are made up as follows:

	2014	2013
	$	$
Salaries, benefits and consulting services	**799,082**	87,579
Other	**199,052**	109,655
One-time expense	**32,533**	-
	1,030,667	197,234

12. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 27 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2014 was $276,881 (2013 - $265,207) for current service costs and is included as an expense in the statement of operations. The last actuarial valuation was completed for the plan on December 31, 2013. At that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provision of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

Waterloo Wellington Local Health Integration Network

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